

THE GIVE AND TAKE
IN HOSPITALS

The Give and Take in Hospitals

A STUDY OF HUMAN ORGANIZATION
IN HOSPITALS

by Temple Burling, M.D.
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A study conducted by the New York State
School of Industrial and Labor Relations,
a unit of the State University of New York
at Cornell University, with the support
and coopération of the American Hospital
Association.

Foreword by George Bugbee

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FOREWORD

THE 7,000 HOSPITALS in this country employ 1,200,000 full-time employees and spend approximately \$4,000,000,000 each year. An intricate network of skills is required to deliver a personal service of a most intimate character.

But hospital service does not stem only from a large working force and great expenditure. The quality of hospital service and public acceptance of the effectiveness of hospital care are almost wholly dependent on two intangibles: the intelligent training and motivation of the individual members of the hospital staff, and the adeptness with which hospital administration melds this complicated mechanism into an efficient instrument for the care of sick people.

Intelligent and sympathetic care of the patient is, of course, the objective of the hospital. This objective may never be wholly attainable in view of the social, psychological, and scientific aspects of hospital care, but even on the simplest basis, attainment means that those who serve and those served must be in very close rapport. Such rapport exists only in well-administered hospitals where the employee understands his duties and responsibilities and where those who administer at each level know the circumstances which confront the employee. It is only in this kind of atmosphere that job satisfaction and employee morale are high; it is only here that intelligent, kindly patient care is possible.

For years the entire question of how to attain better human relations within the hospital has been the concern of the Committee on Personnel Relations of the American Hospital Association. This group has worked to determine how the varied talents and skills of employees in

the hospital may be more efficiently utilized, not only from the standpoint of providing hospital care beyond criticism of patient and physician, but in terms of purely administrative functions as well. This committee was convinced some years ago that only through the most modern, democratic type of administration could true progress be made in rendering service. This implies full knowledge by the employee in his relationships and, most importantly, of his full responsibility in furthering hospital objectives.

This study initiated by the American Hospital Association adds to the field's knowledge of that type of administration. It is directed toward bringing greater understanding of the hospital and its many ramifications to all the people who enter into providing care to the patient—trustees, physicians, administrators, and all the professional and nonprofessional staff. Without recommending a specific course of action, it gives unusual insight into how hospital occupations appear to individual technicians and workers in many hospital departments. As a highly readable report of interaction between administration and employees and, in turn, of the results of this interaction in terms of patient care, it documents the importance of sound employee motivation.

The research for this report was made possible by the cooperation of a number of hospitals throughout the country. Every effort has been made in describing the hospitals which volunteered assistance not to reveal the confidential information which was gathered by field workers during the many months they were in residence. Unfortunately, this makes it impossible to acknowledge the debt owed those individual hospitals for assisting in research by naming them.

Acknowledgment is made, however, of those who contributed to the \$50,000 grant for the study made through the American Hospital Association. These organizations are as follows:

American City Bureau
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Carnegie Corporation of New York
Charles E. Merrill
Johnson & Johnson
Modern Hospital Publishing Company

Finally, the report itself is a credit to the efforts of many individuals. Conducted by the New York State School of Industrial and Labor

Relations at Cornell University under the able direction of Dr. Temple Burling and his staff, the research is highly significant to the hospital field. Conduct of the study and interpretation of results were further strengthened by an advisory commission formed at the invitation of the university and the American Hospital Association. Their names are given elsewhere.

GEORGE BUGBEE
President
Health Information Foundation
New York, New York

ACKNOWLEDGMENTS

IN HIS FOREWORD, Mr. George Bugbee gives the story of the way in which the study came about. It was the interest in human relations problems in hospitals, on the part of the American Hospital Association and particularly on the part of Mr. Bugbee, at that time Director of the Association, and of Mrs. Ann Saunders Friend, Personnel Specialist, that provided the initiative and set the general direction of the study. They also obtained the necessary financial support. But we owe them much more than the stimulation of our initial interest and the provision of needed funds. Throughout the course of our investigations they have encouraged us with their continuing interest in the details of our progress and approval of our preliminary reports, pointed out significant problems, warned us against one-sided judgments from too narrow observations, and opened for us the doors of the hospitals in which we did our studies.

Mr. Bugbee also lists the organizations which made financial contributions to the study, and we join him in expressing our gratitude for the generous support we have received.

We are deeply indebted to our Advisory Commission. They helped us to develop our criteria for the choice of hospitals to study, and to find hospitals which met these criteria. They helped us to clarify our objectives. They have read various revisions of the manuscript and given us many constructive criticisms. Their wide background in hospital affairs has been an invaluable check against making too sweeping generalizations from our limited material. Over and over again they have pointed out those features in our hospital report which are generally true and those which were unique to the hospitals we studied.

At the same time they have lived up fully to their title of Advisory Commission. They have consistently refrained from directing us either as to our methods of study or the conclusions we have drawn. The responsibility for this report rests entirely upon the authors.

We owe much to our colleagues at the School of Industrial and Labor Relations. It was Dean Catherwood's interest and approval which made the project possible. He has served as Chairman of the Advisory Commission and has given us encouragement and valuable counsel throughout. The study of our first two hospitals was financed from the research funds of the School, which he made available, before the American Hospital Association had obtained grants to carry it forward. Professor William F. Whyte has been closely associated with the project from the initial discussions with the American Hospital Association, has helped in formulating research plans, and has given much valuable advice about field methods, interpreting our findings and organizing our report.¹ Professor Leonard Adams took part in conferences with the American Hospital Association and the Carnegie Corporation of New York leading to the formal understanding which enabled us to expand the study. Professor Robert Risley and later Mr. Riley Morrison, administrative assistants, took care of the financial details of the grant and relieved the research workers of this responsibility.

We wish to express our appreciation of the work of Dr. John Dean, Mrs. Jean-Ann Gow, Mr. Marvin Okanes, Mr. Stephen Richardson, Miss Margot Schuetz, Mrs. Judith Seaver Shea, and Miss Janet Sperber, who at various times assisted in the field investigation; to Mr. George Strauss, who read and criticized the manuscript and helped to index the field notes, and to Mr. Jiri Kolaja, who helped prepare the bibliography.

We are indebted to the following friends and colleagues in various parts of the United States who read various chapters of this book, and have advised us with our interpretations and with our efforts to distinguish between the features in our report which are generally true and those which are peculiar to particular regions or specific hospitals: Miss Ellen Creamer, Syracuse University, Department of Nursing Education; Miss H. Phoebe Gordon, Personnel Director, The Charles T. Miller Hospital, St. Paul, Minnesota; Miss Sally Heitman, Uni-

¹ The senior author has a special reason to be grateful to Professor Whyte, for it was largely through his efforts that Miss Lentz and Mr. Wilson were found and recruited for the project.

versity of Washington School of Nursing; Dr. Everett C. Hughes, Department of Sociology, University of Chicago.

The secretarial work involved in the study has been very heavy. Miss June Price, Mrs. Mary Kay Sullivan, Mrs. Peggy Parks, Mrs. Maxine Heffron, and Mrs. Katherine Anderson have transcribed thousands of pages of field notes from the dictating machine records and copied innumerable revisions of the various chapters.

We wish to express our appreciation to the Harvard University Press of Cambridge; Physicians' Record Company, Chicago; The American Journal of Nursing, New York; The National League for Nursing Education, New York; and Harcourt, Brace and Company, Inc., New York, for permission to quote from copyright material.

Finally, it is a very great pleasure to acknowledge our debt of gratitude to the hospitals in which the study was made. We wish that the necessity for protecting the anonymity of individuals did not make it impossible to acknowledge them by name. We were intruders in busy institutions engaged in vital work. At the very least we occupied valuable floor space, and inevitably our presence disrupted schedules in spite of our efforts to prevent this. But we were never made to feel like intruders. In our report we have much to say about the satisfactions of hospital work. We might say something here about the satisfactions of research in hospitals. This has been a happy experience for all of us who have taken part in the field study. We feel many warm, personal bonds for workers in all the hospitals we studied. We feel a thrill of pride when we read that one or another of these people with whom we have worked has received an honor. We shall always take an interest in the progress and development of "our" hospitals. In opening their doors to us and making us welcome, the hospitals could expect almost nothing in direct benefit. They accepted the inconvenience of our presence and the annoyance of our probing attitudes, not for any direct benefits to themselves but in the expectation that our findings would be of use to other hospitals throughout the country. As we prepare our report for general distribution, it is our deepest hope that this expectation may, in some measure, be realized. It is the only way we can repay our debt to our hospitals.

INTRODUCTION

Methodology

THE APPLICATION of scientific methods to the study of relationships among people is still so new that even its name means different things to different persons. What we mean by "human relations" is the study of interpersonal relationships which become typical among people who live and work in concert. In this study we tried to see the place of the hospital as an institution among other institutions in the American community. We tried to ascertain what kinds of people are attracted to its employ, what rewards they hope to get from their work, what rewards they actually do get, and what price they pay. We wanted to know how people manage to merge their mutual purposes, and to get along with one another within the work situation. Where do they grow in cooperativeness and under what circumstances does cooperation tend to wilt? We tried to see not only individuals but groups, to determine the attitudes and patterns of adjustment which group membership brings to pass among those engaged in various occupational types of activity within the hospital.

In our work we used the clinical approach, much as a doctor would do. We studied one case at a time, seeing it in its total environment and as a complex of phenomena. We relied upon subjective as well as objective data, asking the subject how he felt as well as looking at the evidence. We tried to observe as many cases of a given kind as possible and to interpret the differences among them with as much insight as could be mustered. We tried not to deceive ourselves that our knowledge was pure, but worked constantly and humbly with the realization

in mind that the next case was sure to be different from anything we had yet seen.

When this study first began, only slight attention had been given by social scientists to the problems of the general hospital. The field of mental health had been more successful in commanding their interest, but many of the findings in that area did not apply to the general institution. Oswald Hall at McGill University, Everett C. Hughes at the University of Chicago, Leo W. Simmons at Yale, and Talcott Parsons at Harvard had been encouraging interest in the medical sciences, but their students had only begun to work in this area. It was therefore decided that the most logical approach for us to take was the social-anthropological one. It was almost as if a new continent were to be explored. The problem included the mapping of the territory, so to speak, an analysis of its parts and their relation to each other, the nature of its peoples and their institutionalized patterns of behavior. At first we attempted to note all possibly relevant material. In time our attention became more focused, as consistent patterns began to

When we became clear as to what the most important variables we selected six hospitals with the help of our Advisory Com-
The study therefore could be said to have evolved, each step being based upon the one previous to it.

At first only one person was employed in the field, but the staff expanded as our purpose clarified. The time spent in any one hospital varied from one week to a year, its length depending upon the time it was studied, the size of the institution, and the number of persons available to do the work. A total of five years went into the project, including its planning, execution, and analysis. This included the period from the summer of 1949 until the summer of 1954.

Personnel

Dr. Temple Burling was appointed director of the study. Dr. Burling is a practicing psychiatrist and faculty member of the New York State School of Industrial and Labor Relations. Miss Edith M. Lentz was appointed field director. Her training was in sociology, as was that of Dr. Robert N. Wilson, who was appointed as full-time research associate. Dr. Wilson also had training in psychological tests and measurements. Several graduate students were employed for various periods of time on different phases of the work. Their background was in psychology, human relations, or industrial relations. These included Jean-Ann Pierce Gow, Marvin Okanes, Stephen A. Richardson, Margot

Schuetze, and Jiri Kolaja, who served as bibliographer. George Strauss helped us to index materials. Mrs. Judith Seaver Shea, who had been trained in field work as a staff member of the National Opinion Research Center, worked with us for a longer period of time than the others, both in the field and in analyzing materials. None of these field workers was educated in the medical sciences. The assumption was that an easier rapport and a more objective view could be achieved by a total outsider than by persons who already had strong feelings about one or more phases of hospital life, and of course Dr. Burling, medically sophisticated, was always there to correct any gross misconceptions.

The need for the guidance of those ripe in experience was further satisfied by the selection of our Advisory Commission, the members of which represented the viewpoints of hospital administrators, physicians, nurses, trustees, ladies' auxiliaries, hospital publications, business and industry, and the university.

Selection of Hospitals

There are many kinds of hospitals in America today and it was felt necessary to limit this study to those in one broad general category. This was the most familiar type; the community hospital operated under the auspices of a voluntary organization for nonprofit purposes, where general medical and surgical care is offered and most patients are short-term guests. This excludes several important types of medical institution, such as the tax-supported hospitals and those offering treatment for specific diseases such as tuberculosis, mental disorders, etc. As the study progressed certain variables were seen to have important bearing upon the patterning of relationships. These included such factors as size of the hospital, rural-urban environment, the degree of medical specialization, the degree of affiliation with other institutions, and geographical placement. We wanted a variety of circumstances to be represented and therefore selected hospitals which ranged from fifty to eight hundred and fifty beds. One was located in a metropolitan community, two were in a smaller and more homogeneous town, and three were in rural or semirural areas. One hospital was maintained by a religious order. One was a teaching hospital with university affiliations where almost all of the doctors were specialists. Several hospitals had open staffs and their own nursing schools. Three had very few medical specialists and were without nursing schools or other affiliations. A variety of administrators were observed, including both professionally trained and laymen, men and women, doctors

and nurses. All of the institutions studied were members of the American Hospital Association and all of them had boards of trustees composed of community leaders rather than medical specialists. We strove to get as wide a variety of situations as possible within the general category, and at the same time to select fairly representative types.

The geographical location and the total number of hospitals studied represented a compromise between what was thought best and what was possible within the limitations of time, money, and personnel. Most of the work was done within New York State but we did not include any hospital in New York City. It was felt that hospitals there were exceptional in their development, and therefore less helpful for our progress. We studied two hospitals in the Southern states.

As preliminary findings were drawn up, they were circulated among informed persons in other parts of the United States and criticisms of these readers helped us to recognize where our materials were inadequate from the standpoint of regional coverage. We have endeavored to point out the limitations found in our materials, at relevant places in this book.

Procedure

In some cases the initial contact with a hospital was made by approaching its administrator directly. In others we worked through a member of the board of trustees. Toward the end of the study, initial overtures came through the American Hospital Association. In any case where hesitation was shown, we did not pursue the matter further, for we believed that a willingness to cooperate was crucial to the success of the research. However, the usual response was a cordial welcome. We were repeatedly struck by the earnest effort on the part of many hospital officials to face and master the problems which beset them.

Once inside the hospital, a good bit of time was spent in poring over such documents as were available in the hospital's main offices. We studied personnel records, noting names, ages, length of employment, and wage rates within all hospital departments. This gave us a total view of the institution and a way to compare departments with each other. This book purposefully does not stress economic factors, but we were not unmindful of their importance in shaping human relationships. Therefore we took careful note of comparative wage rates within each hospital and tried to gauge the differences between its wages and

those paid in the surrounding community. We noted the economic state of the hospital as reflected in its trial balance sheet; the reputation it had among employees for willingness to adjust its salary scales with the changing times, its ability to purchase modern equipment, and its attitude toward accommodating the various classes of patients. All of these factors had their influence on morale and were kept in mind throughout the study. None of the hospitals we observed had labor union affiliation. Unions were not common in hospitals in the areas of our study, so we have no knowledge of their influence in this occupational field.

Economic concerns are of utmost importance to the administrator, of course, so he could understand and respect our interest in them. During this early interlude he learned by our daily presence that we went our quiet way, observing and asking questions but not disrupting work routines; staying out of busy people's way until they could afford time to confer with us. We made a practice of returning to the administrator at intervals to keep him informed of our progress and of any problems which arose, so that he continued to feel in control of the situation.

In each department we followed a similar course. We would speak first to the person in charge, asking permission to look at whatever records seemed available and of interest. On nursing floors, for example, these would include work sheets, time books, and patients' charts. Thus knowledge was gained about patient loads and the number and kinds of personnel available to take care of them.

As the hospital staff grew accustomed to our presence, we ventured to volunteer our services for minor chores. We toted water, made empty beds, amused bored patients, cut meat. In one hospital one of us donned the uniform of a student nurse and accompanied the probationers in all of their duties for a week. At all times everyone concerned knew who we were and what we were doing. It was our business to make them conversant with the broader aims of the project and to win their participation in it so that they voluntarily took us around and opened our eyes to many things. Just as in the original selection of hospitals, where any reluctance was shown we withdrew until it disappeared. This avoidance of pressure seemed to us to increase the confidence people grew to have in the study. Our willingness to help made us friends and we felt that we fitted more naturally into the environment than we would have done just sitting around staring.

Between and during chores, of course, we were observing. We noted

the physical setting, the type of technology in use, the way in which work was organized. We noted who talked to whom in the course of their work and what signs of authority were in evidence. We observed student nurses to see whether they freely approached graduates and doctors to ask them questions, or whether they hid down the hall in an empty room until summoned. We talked casually to patients, noting whether they seemed bored or irritated, whether they ventured forth as convalescents to visit other patients on the floor or whether they stayed strictly to themselves. All these things helped to improve our understanding of the total work situation in which people found themselves. In the light of this knowledge, individual interviews became more meaningful. As the interviews proceeded, the bits and pieces of information would gradually fall into place and we would feel that we had caught the spirit and temper of that department. Then we were ready to move on to the next one.

In this way we studied the entire hospital, or as representative a sample of it as we could cover. We attended any meetings we could win admission to, from sessions of the board of trustees to informal chats over soda pop. We ate with employees and with supervisors, enjoyed recreation with them, in one instance lived in the nurses' home. In all of the hospitals studied, it seemed to us, the acceptance of us as people increased with the length of our stay so that employees freely gave us insight which we would never have gained otherwise, and took us for their friends. We sincerely hope that this book will prove the wisdom of their trust.

The Use of Materials

By the time field work was completed, there were file cases of data to be analyzed. This included a variety of documents: statistics, financial records, personal papers given us by respondents, newspaper clippings, hospital histories, by-laws of medical staffs, and so on. There were our own voluminous notes including tentative analyses of departments and hospitals, hypotheses, and work diaries. And, of course, there were stacks of interviews.

The interviewing, for the most part, was of the variety termed "semistructured." That is to say, we did not ordinarily approach people with already formulated questions, but rather with broad general topics for discussion. For example, we customarily asked them to tell us about their background and previous work experience, about their present duties and how they felt about them, about the people they worked

with, and about their plans for the future. Wherever possible we encouraged them to give concrete examples of things which caused them satisfaction or grief. We tried to follow their lead, letting them talk about the aspects of their work which interested them most, in the belief that this provided the richest insights into their personality. Usually these interviews were held as close to their work as privacy could be found, and on an informal and intimate basis. No notes were taken in most interviews. Occasionally we deviated from this course, keeping a flexible approach to match the apparent needs of the moment. Our custom was to return to our office as soon after each interview as possible, to dictate our recollections of what had taken place. The quotations in this book, therefore, are not to be taken as exact replicas of what was said but rather as recollected conversations subject to the distortion of fallible human memory but recorded as near verbatim as possible.¹

Although the interviews may have seemed broad and shapeless to our respondents, they did follow a pattern. We were influenced in our work in large measure by the "interactionist" school of thought in the field of applied anthropology, particularly by William Foote Whyte and George Homans. Like them, we concentrated particularly upon the relationships among people, especially between occupational groups, and the sentiments which arose from these contacts. We tried to see how relationships were influenced by technological arrangements, by work organization, and by such diffuse things as the relations between the hospital and its total environment. Students of sociology will also recognize the influences of Max Weber, Robert Merton, and Talcott Parsons, all of whom concerned themselves with the nature of organizations. The work of Everett C. Hughes on occupational groups also helped to shape our understandings. While we tried not to be bound by any one theoretical approach, it is obvious that these frames of reference did influence the way we interpreted what we saw in empirical reality.

Our analysis of materials, then, was based upon the total context of our knowledge both of the specific situations observed and of the insights gained from reading and study in the fields of hospital organization and of general sociological and psychological literature. As a particular aspect began to shape itself in our thinking, we would

¹ In reporting these quotations, care has been taken to disguise all names and to remove identifying elements insofar as this was possible to do without distorting the context.

endeavor to write down the essence of it and then to show it to the people most immediately concerned. For example, a tentative analysis of the admissions office and its problems was read and discussed by the staff of the admissions department in the hospital we were then studying. With their consent it was then shown to the hospital administrator for further criticism. Once it met with the general approval of these people, it was sent on to informed persons in various parts of the United States for criticism. These included both hospital and university people who were conversant with hospital situations. Our most searching critics, of course, were the members of our advisory commission. They helped us to see where our findings were based upon an inadequate sample, where they needed further verification. This was not a board of censorship. We were entirely free to write the truth as we saw it, hence they are not responsible for the final product. We were, however, guided and strengthened by the counsel of these experienced people.

What This Book Represents

In summary, the present writing represents an analysis of what we saw and heard in six hospitals, selected for their representativeness among hospitals of the most familiar type in the United States today: the general, nonprofit, privately managed hospital established to serve the entire community. These hospitals were located in three states, all in the Eastern part of the nation. We interviewed approximately a thousand persons, many of whom had had a wide experience in hospitals elsewhere. They came from all levels of the hospital system, from board members to part-time laborers. The interview data were supplemented by observations in all hospital departments. The study was done in the early half of the 1950's when hospitals were still in process of adjusting to the multitudinous changes which had occurred during the war and postwar periods.

This book does not pretend to tell the whole story about hospitals in general. It does not even tell the full story about the specific ones studied, for we were outsiders. It does, however, present a broad perspective on the American hospital system, for we were free to regard it from the standpoint of many different occupational groups. It is our hope that the people who have responsibility for our nation's hospitals will recognize something in this book which resembles their own situation, and that it may thus help to widen their perspective and give them stimulation to examine further the forces which shape the human

situation where they are. The outsider, as we see it, can point out common problems and can excite interest and curiosity. It is only the insider who can hope to see the full picture and therefore it is he alone who can take appropriate action to strengthen the hands of those who do the work. Our profound respect and good wishes go to these people.

T. B.

E. M. L.

R. N. W.

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HUMAN RELATIONS IN THE HOSPITAL ORGANIZATION

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PART ONE

HOSPITALS AND THE
AMERICAN SCENE

CHAPTER 1

THE HOSPITAL IN ITS HISTORICAL SETTING

THE HOSPITAL, despite its emphasis on specialized techniques and equipment, is basically an organization of human beings. Many professions and occupations are brought together in a single place to focus their skills on the central goal of patient care. The scientific excellence of modern medicine can be brought to bear on patients' needs only if the human agents are in a flexible and creative relationship with one another and with the patient. Medical treatment is not automatic or routine but is a delicately balanced cooperative achievement.

We hope that our study of human relations in hospitals will make a contribution to this joint enterprise. Many working groups have been studied in manufacturing organizations, and accepted principles of human relations are applicable to the hospital in many respects, but the hospital is also a unique institution and the universal elements of human relations express themselves in ways peculiar to it.

Much of the uniqueness of the hospital stems from the character of its task, but part of it is due to the long and rather tortuous development of the modern institution from its medieval beginnings. This chapter attempts to follow certain features in this history which continue to the present day to affect human relationships within hospitals.

1. The Evolution of the Modern Hospital

Although there were hospital-like institutions in the ancient world and in the Orient, they have had only an indirect influence on the

development of their modern Western counterparts. The modern hospital in the Western world has grown out of the European medieval institution of the same name, but with a different function. The enthusiasm for religious pilgrimages in the Age of Faith, at a time when commercial inns had not appeared, meant that many travelers were in need of lodging. The religious organizations, assisted by pious gifts of wealthy laymen, met this need by founding and administering lodging houses, named hospitals.¹ In the beginning, accommodation was often given for only one night and the guest was expected to resume his pilgrimage in the morning; but in time the hospitals began to take in the homeless within their own cities, and give them more permanent lodging.

Thus in its origin the hospital was not a medical institution, nor even concerned with the care of the sick. Since many of the homeless unfortunates were physically ill, however, nursing care was necessary, and in time medical consultation was sought. The medicine of the time had really little to offer these patients. Most of them were suffering from chronic or terminal illnesses, and the hospital undertook to make them as comfortable as possible with the resources and knowledge available, until they ended their days.

The services of such doctors as did visit the hospital were often a gift of their time to the unfortunate. They did not see any immediate advantage to themselves in giving their service. Their only reward for succoring the unfortunate lay in their hopes of a life to come. The focus of medical practice at that time was in the home. It was there the doctor found the resources which he needed for his patients: relatives to provide nursing care, food and shelter. Even up to the middle of the last century the hospital provided a wretched substitute for home care. In 1788 the death rate among patients at the Hôtel Dieu in Paris was 25 per cent, and that of surgeons and attendants from 6 to 12 per cent per annum. It was noted at this time that those attendants who lived outside the hospital were usually much stronger and healthier than those who lived in.²

The rise of modern medicine has resulted in a transformation of the hospital both in its methods of care and its relations to the community. Florence Nightingale's recognition of the relationship be-

¹ From the Latin *hospes*, host.

² S. S. Goldwater, M.D. "Concerning Hospital Origins," in *The Hospital in Modern Society*, ed. by Arthur C. Bachmeyer, M.D., and Gerard Hartman. New York: Commonwealth Fund, 1943, p. 9.

tween filth and hospital death rates, and the explanation of this relationship provided by Pasteur, have made it possible to control hospital epidemics. The hospital is now safer than the home.

While Miss Nightingale and the followers of Pasteur were making it safe for people to go to hospitals, the development of modern medicine was making it more and more desirable for them to do so and at the same time increasing the value of the hospital to the doctor.

Doctors needed more precise control of patient care than was possible with unskilled attendants in the home, if they were to give their patients the full benefit of scientific advances. Highly skilled nursing was vital. The reforms in nursing education which occurred at this time provided young women equipped with the needed skills. This training was given in the hospital. Gradually it was realized that the skills developed there could be helpful to nurses who were employed to care for sick people in their homes. But their services could be directed and utilized more effectively in a special institution.

Precise and elaborate rituals of aseptic surgery could be observed more easily in a special wing of a special building than in a hurriedly rearranged bedroom or domestic kitchen. When aseptic methods made it safe for the surgeon to open the abdomen, and other body cavities, there was a rapid increase in the number and complexity of operations which he dared perform. This resulted in such a great increase in the number and complexity of surgical instruments that transporting them became a problem. During the past fifty years clinical applications of research discoveries such as x-ray, the measurement of basal metabolism, the electrocardiograph, and radioactive isotopes, necessitated the development of costly and bulky equipment. Laboratory examinations were becoming increasingly important in patient care and could be made available more promptly and efficiently when the patients were gathered under one roof than when they were scattered through residential areas.

As a result of these developments, the hospital became the place where the best, rather than the worst, care could be given—first to surgical patients and later to an increasing number suffering from medical illnesses. At length it was only in the hospital that the doctor could find resources for the care of many of his patients at a cost which was not prohibitive.

Meanwhile the hospital was growing more useful to the doctor in other ways than direct patient care. It became essential to his professional training as a medical student and intern, and equally vital to

his continued professional growth after graduation. It brought him into stimulating daily contact with his colleagues, facilitating consultations and exchange of ideas, and it provided a natural setting for lectures and symposia. Increasingly, medical research was carried on in the hospital, since there the patients were under twenty-four-hour observation of skilled observers, prompt comparisons could be made, laboratory facilities were at hand, and clinical records could be centralized and indexed. And finally, it was to the advantage of both the physician and the patient that the hospital practice was a great time-saver. It enabled the doctor to devote a larger percentage of his working day to the care of the patients and a much smaller percentage to travel.

II. The Modern Hospital: The Result of Evolutionary Adaptation Rather Than Rational Planning

When the development of medicine confronted doctors with the need for an institution to which they could bring their private patients, there was already in existence one in which a portion of the sick population was being cared for. Medical practices changed slowly enough to enable the hospital to make itself over almost imperceptibly and to fulfill the doctors' requirements at every stage in the development. But the institution as we know it today would probably be considerably different if the medical profession had had to create it. In America, today, private voluntary hospitals provide most of the hospital beds (other than those in mental institutions). Yet the doctor is still not fully a part of the organization, despite close relationship between the hospital and medical practice. He does not exercise direct control of it, nor is he in turn under effective control by the hospital administration. Because they share a strong concern for the care of the sick, the hospital and the doctor work together in close cooperation, but this is largely the result of mutual accommodation rather than formal organization. The doctor is still officially a guest of the institution.

The changes which we have been describing steadily increased the complexities of organizations and changed the established patterns of human relations within the hospital. Although the pressure for these changes has often come directly or indirectly from doctors, with rare exceptions they have not concerned themselves with the resulting administrative problems. In fact, they have for the most part been little aware of the administrative and human relations skills involved in providing the services they have required for their patients.

Interest in the welfare of the sick, and the readiness of the hospital administration to change with changing times and changing needs, has resulted in an institution which has almost nothing in common except its name with the medieval institution from which it has grown. It has changed from a marginal and charitable interest of the doctor to one of the most important aspects of medical practice and an essential center of medical development. It formerly served only the most unfortunate stratum of society. As late as 1929, Dr. Nathaniel W. Faxon could quote with approval the description of the hospital as "the abode of charity, the treasury into which the rich pour their wealth and the poor their poverty."³ Now, however, to an increasing degree the hospital serves the entire community and turns to it for support.⁴ Even a hundred and fifty years ago, the hospital was the last resort of the helpless and dying. It is now, in some instances at least, the first resort of people suffering from even minor illnesses. In the Middle Ages the hospital attempted to alleviate a broad range of human ills—poverty and homelessness as well as disease. It gradually narrowed its focus to the combating of bodily disease. Now it is beginning once again to concern itself with the patient as a whole person, in line with a broadening conception of disease to include psychic and social maladjustment as well as physical disorder.

We have spoken of the evolutionary changes of the hospital as if they had occurred in the past, but they are still going on. In fact, probably never in the history of hospitals have developments been more widespread and rapid than they are at the present time.

III. The Effects of Recent Broad Social Changes

Economic changes during the past twenty years have been among the most important causes of these recent and continuing developments. Hospitals, as charitable institutions, have traditionally operated at a deficit made good by wealthy donors. Even after the hospital had come to serve the entire community, this tradition tended to persist. The depression of the 30's disastrously reduced the contributions of wealthy patrons; in the years since, the costs of building and operating hospitals have risen so rapidly that administrators have been faced with recurrent deficits in spite of the generosity of donors. They have re-

³ *Ibid.*, p. 13.

⁴ In 1954 the total expenditures for all nonfederal hospitals was \$3,910,180,000. The capital investment was \$6,600,423,000. The number of beds was 623,994. (Figures supplied by the American Hospital Association.)

comings in the over-all way in which health needs were being met. In the following years various national societies to combat specific illnesses were organized, and each of these in its reports to the public pointed out that our efforts to combat and overcome these diseases fell short of our theoretical knowledge. The impression made by these reports was re-enforced during both the world wars by the disturbingly large percentage of young men who were found unfit for military service and the reports that in many instances the defects were remediable or could have been prevented. At the same time, labor shortages brought to public attention the fact that the health of the citizen is of immeasurable importance not only to the individual but to the nation in peace as well as war. Along with an increased concern about the national health there was a growing conviction that the best of health care is a basic and inalienable human right.

Credits as well as debits in the health story also had their share in a growing public interest in health matters. Life expectancy had a steady and rapid increase. The program of public health reduced and in some cases practically eliminated some of mankind's severest scourges. There was an unprecedented increase in the doctor's effective therapeutic resources. These achievements were very newsworthy and received wide publicity. People became more optimistic than ever before about the possibility of achieving and maintaining both individual and national health and began to feel that they had a right not only to the best possible care but to cure as well.⁶

Probably there was never such widespread recognition of the importance of health, nor such concern over the lag between scientific advances and the spread of their benefits throughout the country. As never before, the protection of health was recognized as a concern not only of the individual and of the local community but of the nation. This led to the development of national organizations which had as one of their aims to diminish the gap between the best possible and actual medical care, through *accrediting procedures and moral pressures*. The American Medical Association (1847), the American College of Physicians (1915), the American College of Surgeons (1913), the American Nursing Association (1897), and other organizations of medical specialists promulgated standards for one or another aspect of hospital

⁶ It is hard to accept the fact that there are still diseases for which there is no known effective therapy when many hitherto uncontrollable diseases can now be cured. When the doctor has to tell a patient that there is no specific remedy for his condition, he is apt to feel affronted, or to wonder if his doctor is keeping abreast of the times.

activity which the hospitals must meet if they were to remain in good standing. In 1951 the American Hospital Association, the American College of Surgeons, the American Medical Association, and the Canadian Medical Association set up a Joint Commission on Accreditation of Hospitals.

Various research foundations made studies of hospital problems and offered advice and leadership to local and regional organizations to help them adapt successfully to changing conditions, without attempting to engage in accreditation.

The hospitals themselves also recognized early that health was more than a local concern. They organized the American Hospital Association in 1898 to help one another raise standards and develop ways of performing their work more effectively. More recently the American College of Hospital Administrators (1934) was organized to promote professional responsibility and growth in its members. Regional hospital associations were formed to help members meet local problems and to work toward a comprehensive cooperative coverage of the hospital needs of their areas.

The Hill-Burton Act was a response to the postwar crisis arising from the increased recognition of the need for hospitals. The framers of this measure were guided by the purpose of providing local communities with needed hospital facilities, while scrupulously avoiding centralized control over local hospital policy.

As a result of these national developments, in which hospital leaders have had a leading role, hospitals are no longer merely local institutions concerned only with problems at their doorsteps. They have become an active part of a national network of health agencies. These agencies voluntarily support and supplement one another's efforts from a sense of common responsibility, and they subtly influence each other. But there is no over-all centralized control. Hospital policies which govern internal and local relationships remain in local hands. The individual voluntary hospital retains great flexibility, enabling it to adapt itself to the problems of its community and to experiment with new ways of accomplishing its purposes.

CHAPTER 2

THE INDIVIDUAL HOSPITAL AND ITS LOCAL COMMUNITY

SO FAR, discussion has centered around "American hospitals" as if they were alike in the problems they face. Obviously this is not the whole story. The total society does set a broad framework within which all of its institutions exist, but in addition each hospital is influenced by its more immediate environment. A town with marked civic pride in its hospital produces different attitudes among those who work there from those of employees in a hospital where local citizens are indifferent to it. Since employee morale is subject to the pressure of community sentiments, it may be well to inquire into the nature of community-hospital relationships.

We found that patterns differed from one geographical region to another. Contrasting relationships were also noted in metropolitan hospitals from those in small towns or rural districts. Even within the same town, people were seen to be discriminating between two hospitals according to local traditions and history. Public relations are a two-way thing. The community presses in on the hospital in certain respects, and hospital policies press back into the community to change its opinions and to create new ones. The give and take between an institution and its environment can support or frustrate hospital purposes. Certainly community attitudes help to determine the limits within which hospital authorities are free to act.

Regional Differences

Along the Atlantic seacoast it once was traditional for wealthy citizens to found hospitals. These were planned as charitable institutions for the care of the very poor. In the South, at least in rural areas, hospitals were typically founded by a local surgeon primarily as a workshop for his own use and convenience. In the Far West, the towns and cities were built at a later date than those in the eastern regions. Hospitals already had assumed a different role in the community, as we shall note later. In addition, the extremes of wealth and poverty did not exist in the same proportions and hospitals were frequently subsidized by the total community and operated on a pay-as-you-go basis from the start.

Today the voluntary hospitals in all sections of the country are similar to each other in many respects. They serve all classes of people and get funds from a variety of sources. The person who moves from one section of a country to another, however, soon becomes aware of the significance of underlying traditions, and can see that they still have their influence on public relations.

We observed in one instance the bewilderment of Northerners who worked in a Southern town. The citizens there continually criticized the local hospital because it wasn't well staffed over week ends. The trouble lay in the fact that there weren't enough interns and nurses to go around. One of these "foreigners" inquired why the community didn't provide money for more modern equipment as a means of making the hospital more attractive to potential interns and nurses. The townspeople were astonished and hurt by the suggestion. It was Dr. Jones' hospital, wasn't it? ¹ Why should anybody expect them to give money to him? Actually it hadn't been strictly "Dr. Jones' hospital" for years and years, but they still acted as if it were.

Another town in the South was providing almost no funds for the care of medical indigents, and the small hospital had that cost added to all its other expenses. The physical plant was badly run down and the board of trustees, despairing of raising funds from the community, turned to the government for Hill-Burton money and paid the hospital's portion from its shrinking bank account. Later these board members said gloomily that they were "taking money from Uncle Sam just like those creeping Socialists up North." They felt that somehow

¹ All names, place references, and quotations in this book have been disguised to protect the anonymity of our respondents.

they had failed both the hospital and the community by not bringing them into a "proper relationship," i.e., not re-educating them according to present realities.

Northern cities had similar problems of community re-education. Where a hospital had been subsidized by wealthy donors for many years, local people came to take for granted that the sick would be cared for regardless of their ability to pay, and that hospital bills would be below cost. When such a hospital attempted to meet its spiraling costs by charging people the full price of their care, cries of outrage arose from local citizens. Perhaps it had never occurred to them to wonder how hospital expenses were met. Subsidized care had always been available. Suddenly it wasn't available any more, and they found this hard to accept.

We had no opportunity to study Western hospitals, nor indeed any others which had always been supported by the total community. Presumably these particular problems would not exist in the same measure, but even there one might expect to find difficulties arising from the increasing cost of operation, perhaps in the form of growing political pressures. The effect of change in the method of financial support on human relations within an organization and on its relationship to the community presents a challenging area for further study.

Contrasting ideas about medical practitioners and their role in the community may also be found in different geographical regions. Talcott Parsons² studied the medical profession in Boston and concluded that in that area at least the doctor was no longer regarded as a "generalized wiseman" but was seen by most people to be a variety of specialist with expert skills in one scientific field. It seemed to us that as we moved further inland and southward, the doctor retained more of his traditional prestige. "Generalized wiseman" is a very good description of the role he played in some communities. We saw the town doctor acting as substitute preacher, as head of the local school board, as leader in civic and social organizations. One grateful patient remarked of his physician, "He was more than our doctor, he was our spiritual adviser." What does it do to a man's relationships within the hospital when he is treated with such respect outside of it? One disgruntled office worker complained:

The trouble with our doctors is, they have been spoiled rotten by this town. People think they are gods, capable of doing no wrong.

² Talcott Parsons, *The Social System*. Glencoe, Illinois: The Free Press, 1951, Chapter X.

It is probable that the respect which formerly was accorded to all of our professional groups is now in process of change, as the general educational level of our society rises, but the extent of that change may vary from one locality to another. Where the doctor is treated with something close to idolatry his relationships will differ from those of doctors in areas where they are seen to be one kind of scientist among others.

Nurses called another possible regional difference to our attention. They insisted that in the South the doctor-nurse relationship was modified by "Southern chivalry." A nurse who received her professional training in the North said:

I have to admit, down South the doctors were more gentlemanly. Chivalry really works down there. For instance, up here we are always carting things around, but down South if anybody saw you trying to haul a cart around, they would rush over and say, "You aren't supposed to do that, it is too heavy for you. Here, let me do it." And so they would take over all the heavy work. I have to admit, the Southerners were gentlemanly toward us nurses.

We were skeptical until we went South and found, to our surprise, that the doctors in the hospitals we studied really did treat the nurses more courteously. The nurses related to us how they had taught Southern manners to certain interns and doctors who came from the North. They took them gently to task, for example, for using profanity in the presence of a nurse. The hospital administrator agreed that this was true, and commented:

I saw too much of that sort of thing during my intern days in New York and right from the start was determined not to have it down here. We just never let it get started.

One problem which the Southern hospital seemed to experience more intensely than did Northern ones of our acquaintance was that of maintaining official visiting hours. Until recently, one Southern hospital had allowed almost unrestricted access to its patients. We heard, for example, that in the past family members had brought cots with them from home and insisted on sleeping beside their hospitalized sick. In this part of the South, and possibly throughout the South generally, family relationships are traditionally very close. It is possible that the sick individual has greater psychological need for his kinfolk than would a person who comes from a cultural area where family ties are loosened earlier. At any rate, the Southern hospitals we studied were

finding it difficult to keep visiting hours regulated and the extent of the difficulty seemed to us to be greater than elsewhere.

More data than we have now would be needed before it could be said that any of these variations are truly regional in character. These few observations, however, may be sufficient to indicate that it is dangerous to overgeneralize about "hospitals" or "doctors" or "patients" as if all were alike. Situations change and they do not always change everywhere at the same rate of speed. Regional and local tradition and social custom may act to modify broad trends.

City and Small-Town Differences

The data in this part of the chapter might almost as easily have been classified under headings "big versus small hospitals," or "rich versus poor hospitals," or even "research and nonresearch institutions." However, all of these factors seem to come within an even more basic distinction between metropolitan versus small-town hospitals. A big city provides an abundance of patients for clinical material and the research possibilities in a hospital in such a situation may attract outstanding names in the fields of medical sciences. In the train of the great men will come young and ambitious students and wealthy patients. As the prestige of a hospital expands, its powers of attraction continue to grow. There are negative attributes to bigness too, of course, and these will be examined later, but first one must admit the very real advantages which accompany a metropolitan location.

A big city institution which is willing to pay the price can set high standards of selection in all classifications of personnel simply because it has a larger labor market to choose from. It may be selective even in its choice of trustees, for there are more prominent citizens to choose among. The small rural hospital must make the best of the human materials close at hand. Even in the big city, of course, not all hospitals are big. The smaller ones may resemble those of similar size in small towns more than they do their larger neighbors in the metropolis.

The large cities typically have many hospitals, and in time a division of work may occur among them. For example, one hospital may take the majority of medical indigents, thus easing the financial strain on the others. A hospital may acquire a specialist who becomes famous for a particular type of surgery and thus come to emphasize the surgical arts. Another hospital may gain a reputation for being patronized by the very rich, or a particular religious group. Physicians, patients,

and townspeople generally become acquainted with the reputation of local hospitals and choose among them accordingly.

A hospital with a fashionable clientele sometimes attracts two opposite kinds of people. The very rich may serve on its boards and committees and also come to it as patients, while the very poor will also be attracted because there will be larger funds for charitable purposes there. A hospital which is not patronized by the social elite nor supported by taxes may be unable to attract either extreme, for it lacks funds for charity, and personnel enough to give special service to the rich. It is more likely to attract persons from the middle strata of society at all levels from trustees to patients, and to watch its budget at every step of the way. It cannot compete with the richer hospital either for clinical material nor for research funds but, like the small-town institution, it may offer patients and personnel a greater warmth and intimacy.

Patients sometimes get their own ideas about which hospital is "good" or "bad." These notions may be based upon first-hand information, or they may be entirely irrational or based only on hearsay reports and local prejudice. In a small town, people sometimes have no choice and must use the only hospital within reach of their homes. In the city they have more latitude.

Not only are city hospitals influenced by the reputation and practices of other hospitals, but they are hemmed in by other types of institutions as well. Since any major industries are likely to be unionized, the hospital must compete with union wages and fringe benefits to get and keep satisfied employees. It is therefore more likely to have personnel policies similar to those of industry, with carefully structured wage scales, job evaluation systems, and all the rest. Usually where there are unions and major industries there is also a considerable portion of the public which has hospitalization insurance. This may act to stabilize the hospital financially.

These same big industries, however, sometimes attract a footloose population. Where the small-town hospital has a relatively stable labor force, and employees who have known each other all their lives, the city hospital may have many more transient employees who cannot be relied upon to turn up dependably in good times and bad.

The presence of a great population usually leads to the elaboration of social agencies and well-defined patterns for caring for the poor and handicapped. Some small-town hospitals face the heartbreaking task of turning away all but the most desperate cases. Once an impoverished

individual is accepted as a patient, he may be kept in the hospital longer than is medically necessary since there is no welfare system to help him adjust gradually to being on his own again. In the city, the patient without personal financial resources can get help from welfare agencies both before and after hospitalization, a fact which brings a greater ease of mind to hospital personnel, as subsequent quotations will show.

City hospitals are more likely to be associated with universities and medical schools than are hospitals in small towns. This can also affect morale insofar as the affiliation influences the prestige of the hospital.

So far we have described the situation as if from the outside or from a great height. We have seen how hospital management in a metropolitan area has the opportunity to be selective with regard to personnel, while at the same time its freedom is limited by the presence of other institutions. How does such a situation appear to the person who works inside the hospital and looks out upon the community? The same factors which provide freedom of choice to the institution represent competition to the employee; competition for jobs, for recognition, for promotion. An ambitious person may enjoy this strife while another individual may feel that it isn't worth the demands it makes. One young doctor who was highly regarded by his colleagues stated that he had refused an internship at one of the large research centers where he had served as a medical student.

I hated it there. The thing that got me down was this great hierarchy. The medical student was practically dirt. He had to follow the intern around and the intern followed the resident, the resident followed the head resident, and so on up the line. You were always back about eight paces behind the physician and whenever you toured the wards you did it in a great mob. The same thing in the operating room, there were always about seventy fellows ahead of you and the only thing you were allowed to do was to deliver one baby a year, or something. Another thing, there was an awful lot of intrigue going on. Somebody was always sniping at somebody else and you never knew where the next potshot was coming from.

Now at the Samaritan it was altogether different. There were only two interns there at one time and you had an enormous amount of experiences and were put in a position where you had to make a decision. There just wasn't anybody else around to pass it on to, so you acted and learned by acting, rather than having somebody tell you. Maybe that was rough on the patients sometimes, but it was wonderful experience for a young doctor. After all, eventually you have to go out

on your own and face the patient's situation. I felt we got wonderful training. The doctors at Samaritan were swell too. There was a wonderful spirit. You were called "Doctor" right from the start and treated just the same as anybody else. You lost your fear of those men and didn't feel subservient to them. At the other place you always felt as if you were one step above a grasshopper.

If competition is rife, and sometimes distasteful, there are also advantages in this hierarchical structure. There is a stimulation in such a situation which keeps at least some individuals striving to improve the quality of their work. The presence of lower echelons puts pressure on them to keep ahead by constantly adding to their education and experience. Similarly, the knowledge of higher echelons acts both as a discipline and an encouragement, since the system provides authorized or legitimate ways for advancing oneself. For better or worse, depending upon the point of view, the smaller hospital lacks this hierarchical arrangement. For example, one nurse commented:

In the rural hospital, too, many things are left up to one or two people and it can't help but seem arbitrary. You know that your superior can discharge you on impulse and since there aren't any other hospitals in town, you are at his mercy. That is bound to mean tension in the relationship, almost regardless of the personality factors. No matter how well respected the superior may be, a person is going to feel a little nervous when there is only one court of appeal. You might say the grievance procedure is more elaborate in the city, more minds are involved, so the whole thing seems more rational to you. Down here it is all so capricious. There aren't any standards even for wages. It is a matter of individual bargaining and nobody ever apologizes or explains the discrepancies. I guess I'm just not used to that. Another thing, there isn't any room for advancement here either. You have to wait until somebody dies before you can get ahead, and even then there isn't really much distinction. In the city you have wage differentials and increments and everybody knows what they are and where they stand.

This is the comment of a city girl. A girl from a village who had gone to the big city and returned, didn't contradict that story at all but brought a decidedly different perspective to it.

In the city we made better wages, but in the small town you are happier and better off in other respects. For instance down at Metropolitan we weren't even allowed to go out for a piece of candy. If you came in even a little bit late, you were called down. They just had to regiment us there because there were so many nurses and they couldn't afford to

give us privileges, or felt they couldn't. Here you feel perfectly free. Everything is done to make you comfortable, and the girls don't take advantage of it either, they think of each other and everybody pitches in to get the work done. Down at the Metropolitan everybody was just an individual, thinking of themselves. That was true of doctors and nurses and patients too. Here you are much more of a group. The doctor and the nurse and the patient all know each other. They know each other's weakness and strong points and make allowances for them and you all work together toward the same end. It's just a different feeling. At Christmas you have a party and if it is your birthday they'll make you something a little special down in the dining room. There is just that personal touch all along the line. If it wasn't for the wages, none of us would go anywhere else, but as it is, I must admit, you get the feeling sometimes that you can't afford the luxury of staying here.

These quotations have been chosen from extreme points of view in order to bring into clear focus the contrast between city and small town. This is not to say that hospitals in either place necessarily take full advantage of their respective opportunities. Small-town hospitals can be cold too, or relationships may become so uncomfortably close as to seem an invasion of privacy. On the other hand, hospitals need not passively accept their handicaps. Some of the largest have worked hard to increase the warmth of relationships. Generally speaking, however, people who have moved between city and town tend to stress, on the one hand, the advantages of wage and promotional system in the city, and on the other the satisfactions of simplicity and kindness of the small town. Which has most appeal to any one person probably depends upon his individual personality and background.

Two aspects of this city-town comparison brought forth intense feelings among those interviewed. One aspect was the extent of the division of hard labor:

The only thing you were allowed to do was to deliver one baby a year, or something.

While this was an obvious exaggeration, other interns, nurses, and technicians who had trained in the city made similar statements. They reported that the big hospital gave them excellent theoretical training and the opportunity to watch experts at work, but that the presence of large groups of students prevented any but a few from getting sufficient practice of their new skills to build up self-confidence. The small-town nurses insisted that their training was superior for just this reason.

We found that out when we went on affiliation.² They were forever putting our girls in charge of the other students and we caught on to the reason. It was because we could move into any situation and take charge of it and they couldn't. Of course we had been taught a lot of things they hadn't, like how to start intravenouses and how to catheterize patients. When you don't have enough interns to go around, you just have to learn to do such things yourselves. It gives you a feeling of competence, you are a better nurse for it. But those other students, they had to wait and ask an intern to do things for them. We could just pitch in and do most anything.

The other topic on which strong opinions were voiced was the relative warmth of relationships between patients and hospital personnel.

In the large hospital you never really get to know your patients at all, you are too busy to get acquainted with anyone. Here you either know them personally when they first come in, or somebody in your family knows them. Even if it is some old crab, you wait on her anyway because you know perfectly well that if you don't, sooner or later you will hear about it at home as the word gets around town. Also you *want* to take good care of the patients. You know their home circumstances and you can't help but realize what their illness means to them and their families. Of course it has its bad side, too. They expect an awful lot from you. Some of the girls say they'd rather wait on a stranger any day. Besides, sometimes we can see perfectly well that a lot of a patient's trouble may come from his home environment but you have to see him go back to the same situation which made him sick in the first place. And there isn't anybody in town to turn to either; no counselling service, no social workers, nothing. Sometimes that is pretty discouraging.

A small hospital in a big city, like its rural cousin, may draw a large portion of both clientele and employees from its immediate neighborhood. A church-sponsored hospital may fall into such a classification. Its appeal can be primarily to its own religious community, both as a place to work and as a place to be healed. In a sense, such a hospital lives in a subcommunity of its own, a psychological village. Within it there may be all the warmth and intimacy of the small town.

² A small general hospital with a school for nurses will often broaden the experience of these students by sending them "on affiliation" to another institution, where they learn to care for illnesses not covered by their parent institution; for example, tuberculosis or mental diseases. On these affiliations the girls come into contact with students from other schools and have opportunity to compare notes on their respective experiences.

It is probable that the major differences between city and town hospitals are already being sharply diminished. The average small-town hospital today is much better equipped technically than twenty-five years ago, and the big city hospital frequently has made marked advances both in personnel relations and in the psychological care it can offer its patients. Skilled leadership in either situation can mitigate extreme situations. Even with the best possible leadership, however, the problems faced in the city are different from those in the small town.

Community-Hospital Relations in Towns

It was easier to observe the part a hospital plays in the life of a small town than it was in cities. We are not certain the two situations are really comparable. At any rate, in the town the hospital quite obviously is an integral part of the community around it. Any change in the hospital was seen promptly reflected in the form of community response.

For example, the basic organization of one of the hospitals we studied had recently been modified. The doctors in this town had always enjoyed the highest possible reputation. The hospital had become accustomed to having nurse administrators who deferred to the doctors just as everyone else did. During World War II, the younger doctors were drafted by the armed services and the older men were left with an overpowering amount of work. Suspicion arose that under the pressure of quantity the quality of their workmanship was beginning to suffer. Criticism of the hospital began to mount within the community itself and people began to patronize hospitals at a greater distance in preference to the local one. The board of trustees decided to take action. They replaced the nurse superintendent with a man who had a professional degree in hospital administration.

A new set of rules and regulations went into effect. The doctors, after years of untrammelled freedom, began to learn what they must do to retain hospital privileges. They must keep their patients' charts up to date. They must submit all operative materials for laboratory investigation, and so on. The new practices were commonplace in most modern hospitals, but to these doctors they seemed an affront. They didn't like to have somebody giving them orders, even when those orders were agreed upon by the medical staff as a whole. Added to the heat engendered within the hospital was that coming in from the com-

munity. In this small town, wives of hospital trustees and wives of doctors met around bridge tables and veiled references—not too well veiled—were made concerning the way “our doctors” were being “pushed around” by a stranger in town. The force of public opinion was being combined with that of individual doctors and it seemed only a matter of time before the new administrator would give up in despair.

In some communities, people have long memories. To understand why they feel as they do about an institution, it is necessary to look behind present circumstances and get a historical perspective. In one town we found two hospitals. The first was founded by the social elite. Its board came from the “best families in town.” Its doctors, a closed staff, came to have so much prestige that they controlled local medical practice. In time a second hospital was built by a religious agency. Since the religious group which supported it was a minority in town, this hospital had to work hard to win both community support and patronage. It did considerable work among the poor and it appealed to all social classes for funds.

Today these two hospitals are much more similar than they are different. Their financial standing is about equal and many doctors serve on both staffs. From an outsider's point of view, both offer equally good service to all classes of people, yet the community persists in seeing them as very different. The first is considered the more fashionable and in fact does retain a large share of the “carriage trade.” It continues to have the higher medical reputation. The community, however, censures it because it is believed to offer less humanitarian service. People resist, sometimes fiercely, its efforts to collect money on bills and appear to be sincere in believing that it has no moral right to use pressure. Yet “everybody knows” that the other hospital has to struggle along and individuals feel strong community pressure to pay its bills promptly or feel disgraced in front of the neighbors. A survey of public opinion in that area brought out such adverse comments about the elite hospital as these: ▽

When my last child was born, they got real nasty...wanted a certain amount of money...I didn't have any...so they became indignant and so did I.

You don't get good treatment there unless you have money and social status.

X hospital takes anybody, money doesn't matter. It isn't like that at Y.

These community attitudes were reflected in the morale of employees, particularly those in the business offices who had the task of presenting bills.

Since the community survey was completed, the elite hospital has conducted a public campaign for funds. Perhaps people realized at last that this hospital wasn't so very rich after all, since it was soliciting widespread support. At any rate the community responded warmly and the necessary funds were raised. We have no knowledge of the extent to which this campaign may have changed local attitudes, but one may wonder what it means to a hospital when it turns from a small number of wealthy donors to a great many donors of all social backgrounds. Does becoming a donor make an individual more demanding of hospital service? Or, on the contrary, does it give him a fund of good will toward the institution he has helped to support? ✓

One clue to the answer to that problem may be found in the sturdy support given to some hospitals by their women's auxiliaries. It is common in America for groups of women to associate for the purpose of rendering voluntary service to their local hospital. This is in line with our whole tradition of voluntarism, and is looked upon with widespread social approval. The auxiliary often provides the hospital with funds for purposes which otherwise might go unfulfilled, for instance providing a coffee shop for the visitors or raising funds for an otherwise unobtainable iron lung. The auxiliary further supports the hospital with services, for example manning the library cart and making its books available to all of the patients. We did not have opportunity to make the careful study that the auxiliary deserves. It became apparent, however, that sometimes considerable finesse was required on the part of its leaders and the hospital administration if the work and gifts of volunteers were to be incorporated into the life of an ongoing institution most effectively. When these efforts were successful, there were obvious gains in community good will. The sympathies and hard labor of many persons were thus rewarded and the hospital was elevated to a new level of community prestige. The woman's auxiliary in such instances serves as a bridge of good will between the hospital and its community.

To return to finances, there is one more aspect which requires attention. It doesn't help an institution to be favorably located, with the best brains and equipment close at hand, if it can't afford either. In fact, what could be worse? One thing could be worse, we found, and that is the belief that funds were available but being withheld arbitrarily!

There are, it seems, two sides to the financial question. First and most elementary is, how much money is available? Second, what is the attitude which management brings to the subject of expenditures?

In one hospital, the doctors, nurses, and patients seemed uncertain just what the financial status of the institution was. Some believed that it had ample funds and that the administration was just stingy about spending them. Others felt equally sure that the hospital was in seriously straitened circumstances. A survey of student nurses revealed that 31 per cent of them thought the hospital operated at a gross profit, 25 per cent thought it operated at a loss, and 34 per cent thought it was breaking even. What did this mean in community relationships? How could these nurses answer irate patients or neighbors when the subject of hospital prices came up for discussion? We felt that this hospital was paying a high price for its approach to financial problems. A clearer and more realistic policy might have brought about a change for the better in both public relations and employee morale.

Finally, the hospital may be seen to reach back into the community to shape and reshape prevailing opinions concerning it. One important influence stemmed from the attitudes shown by employees, not only toward patients as might be expected, but toward each other as well. Where they were in basic harmony among themselves, we saw them also offering warmth and humanitarian care to patients. The correlation between good employee relationships and constructive attitudes toward patient care seemed too close to be coincidental. Perhaps both were the result of basic satisfaction people were feeling in the work they were doing among people they believed in. One thing seems sure, attitudes are not due to individual personality alone. They are to some measure sustained and nourished (or beaten down and discouraged) by the total situation in which people find themselves. Any program for improving public relations, therefore, might consider the state of mind of hospital employees. One would want to know how much respect supervisors and workers showed to one another in daily and casual contacts, and whether the administrator, the doctors, and trustees were in reasonably harmonious accord. A hospital full of tensions among its work force is not going to be a restful place for patients to recover in.

Summary

Hospitals, like people, take on character and personality. Some attributes arise from the regional or local setting and its traditions

and customs. Any hospital, whether in the big city or small town or rural area, will be influenced by the community from which its patients and employees are drawn. The community knows what prices the hospital charges, what wages it pays, and how its patients are treated. Once it forms an impression of the character of the hospital, that interpretation clings and is very hard to change. Thus historical events influence the present by providing a framework within which it is comprehended.

The hospital, in turn, is an integral part of its community, sharing in its culture and influenced by its social system, its complex of people and institutions. No hospital can be considered as a thing apart. It is this bundle of interrelationships, this network of human understandings and misunderstandings, which makes the study of hospitals so challenging.

CHAPTER 3

THE PATIENT AND HIS FAMILY IN THE HOSPITAL

IT IS IMPOSSIBLE to understand the organization and activities of a hospital without keeping in mind its central function, and the fact that the patient is physically present to remind the workers that that function is patient care. Patients and their families have a continuous and far-reaching influence on relations among the employees.

1. Social Attitudes Toward Disease /

Hospital workers reflect the general attitude of society toward disease. Illness characteristically calls forth a certain inconsistency on the part of well people. On the one hand there is a feeling of compassion and the impulse to help and, on the other, discomfort and a wish to avoid the sick person. The avoidance is particularly pronounced if the possibility of giving effective help is slight. Even professional hospital people must sometimes make a special effort to maintain their interest in the chronically ill.

Society also exhibits an inconsistent attitude toward the relationship of the sick person to his sickness. The sick man is absolved from many social responsibilities. It is recognized that for a time he can't be economically productive. He isn't expected to make the same effort as a well person to maintain pleasant social relations. He has a right to be somewhat pettish. He is not, however, absolved from an effort to get well. He is allowed a little respite from life's full responsibilities but he must make an effort to get back to them. He must use the

healing resources which his society makes available to him. If he is suspected of having become "hospitalized" the sympathy of those caring for him is apt to be withdrawn.

II. The Attitude of the Patient Toward Those Who Care for Him

It is well recognized that the ill person tends to develop a dependent attitude. Illness is not only hampering but frightening and the ill person needs to find a source of security outside himself. The sick and his relatives therefore have a strong tendency to invest the practitioners of the healing arts with an aura of extraordinary ability.

The dependency of the sick man on his esteemed physician gives him comfort but at the same time hurts his self-esteem. Since it is human to protect one's self against self-disparagement by disparaging others, there is also a tendency to belittle the physician and his colleagues. Probably all men everywhere display both of these attitudes but an increased sophistication about medical matters today gives their expression a special character. The rise of the general educational level, the efforts at public education in health matters by various national organizations, and the discovery in recent years by publishers and broadcasters that health information, or misinformation, increases sales, have resulted in patients who are better informed about medical matters than any previous generation and a public who believe themselves to be better informed than they are. Such patients are not as ready as those of the past to accept the physician's unsupported statements. They want explanations and reasons and not merely pronouncements. One of the most frequent complaints we have heard about physicians is, "He won't take time to explain things to me."

This has its repercussions in human relations in the hospital. The doctor in making rounds can spend only a few minutes at the bedside of each patient and often doesn't have time for the extended explanations which the patients crave. Since the nurse is on the nursing floor for long periods, the patient turns to her for explanations and detailed information about his illness. It has been a part of the ethics of nurses and other paramedical workers that they must refer the patient back to his doctor for answers to all such inquiries in order to avoid confusing him. As the patient becomes able to ask more and more penetrating questions, it becomes increasingly difficult for the nurse to parry them without giving him the impression that she knows less about medical matters than he does himself.

III. Effects of Increased Utilization of Hospitals

In Chapter I we pointed out that while the hospital formerly served one segment of the population it now cares for people from all economic levels. In the beginning it served only the indigent. Then, when it became the place of choice for treatment of many conditions, the wealthy began to use the hospital services. It is only in the past quarter-century that people from the middle income groups have begun to come to the hospital in large numbers. Nurses, as a rule, do not come from either very rich or very poor families. Until a short time ago, therefore, they were caring professionally for groups with which they had little nonprofessional contact. This made it relatively easy to establish a purely professional relationship to them. The hospital developed clear, though not consciously formulated, patterns of behavior toward these two groups of patients, which the nurse in training readily made her own. With the sudden influx of patients from the middle income groups, the nurse was confronted with the necessity of relating herself professionally to people with whom she already had patterns of informal behavior. Hospital personnel now must interact with representatives of the entire social spectrum. The appropriate attitudes and behavior are more fluid and less clear than they were in the past.

Formerly going to the hospital was a very momentous step and only the seriously ill considered it. Now hospitalization insurance permits people to seek admission for even minor ailments. It is generally recognized that patients with minor illnesses are less ready to accept the dependency which is involved and are more apt to be critical and demanding. At the same time they do not call forth such strong feelings of sympathy and the desire to help as do the seriously ill. These mildly ill patients "who could just as well be cared for at home" on the whole give hospital personnel less feeling of professional satisfaction than those more obviously in need of care.

Another conspicuous strain which has resulted from the increased use of hospitals stems from physical overcrowding. Patients are kept waiting in the admissions office until a bed is available. More beds are crowded into rooms and wards, and more people are needed to care for patients, so there is a lack of space, interference with one another's work, and greater difficulty in maintaining attractive surroundings.

Until the great expansion in the demand for hospital services, there was little effort to relate hospital charges to the costs of individual

care. The poor received their care as a gift in response to their need. The charges to the wealthy were not based on any careful analysis of actual costs. There was not detailed enough cost accounting to make this possible. In fact it was sometimes assumed that charges should be greater than costs, as this was one way in which the rich could pay for the care of the poor. Hospitalization insurance has brought in more precise cost accounting and an effort to bring charges into line with costs of services. It may be that the patient who feels that he is paying for precisely what he gets tends to be somewhat more demanding.

The greater use of the hospital also has its effect on public relations. There is a much wider first-hand community knowledge of the hospital and more public awareness and concern with its virtues and its shortcomings. This as we shall see has its repercussions on the human relations in the hospital.

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IV. The Influence of Visitors on Relations in the Hospital

The patient usually derives a great deal of emotional support from his family, and regular visits are important to maintain this support. They may be necessary if he is to derive the fullest possible benefit from hospital care. The anxiety of a mother that her young children aren't being properly fed and supervised, or the worry of a breadwinner over family finances, is usually alleviated, at least in part, by family visits. When family ties are maintained, the patient's post-hospital recuperation and return to full activity are smoother.

Visitors often bring to the attention of the nurses situations of which they should be aware, but which patients for one reason or another do not mention. The patient, in the hospital twenty-four hours a day, sees the entire routine and realizes that there are other patients in need of care. His visitor is apt to be aware of only the one patient, and therefore to appear to the nursing personnel to be demanding special privileges and consideration.

Visitors, however, are sometimes a strain for the patient. His friends' tire him or bore him. Tactless relatives may remind him of worries or discourage him about his progress. They have been known to give him medicine of their own choosing or add food to a strictly controlled diet. A nurse reported that she overheard a mother saying to her child, "Here comes that bad old nurse to stick you again." Visitors do complicate hospital activities. Their mere presence interrupts ward

routine, and even the most self-effacing and cooperative consume time which could otherwise be given to patient care.

The problem caused by visitors has grown since hospital beds have been used to capacity. Hospitals nearly all seem to find it necessary to exercise stricter control over hours and numbers of visitors. A ward supervisor said this about the problem of visitors:

For example on the ticket system for visitors, they started that two years ago and it took them two years to get it really running smoothly. Since this town is so small, people were used to a friendly pleasant atmosphere, but when people began taking out Blue Cross insurance and the hospitals became so crowded, we just couldn't keep up with that many people around. There had to be some order.

XV. Relations Among Patients and Possible Significance

The relations among hospital workers are influenced not only by individual patients, but by their interactions with each other. Since the average length of stay in the hospital has been very greatly reduced in recent years, patients have less opportunity than formerly to develop a hospital social life. On the other hand, the increased utilization of hospitals means that patients return more frequently. Through repeated visits they become well acquainted with the hospital and they may even find some patients whom they have known on former visits. There are still a good many conditions which require prolonged hospital care. A patient who had spent five months in a semiprivate room said:

This is my first trip to the hospital in twenty years, so I wasn't quite prepared for it. I was surprised to find out how friendly people are and how quickly you get acquainted with them. Now when I first came I had a fellow in my room named Mr. Wilson. He was here to have his appendix out and he was only here five days, but we got to be bosom pals. In fact he came to visit me after he left. He has a farm and is raising a Palomino pony. He told me all about her, and I know a lot now about horse farming I never knew before.

The next fellow to come in was an Italian and the same thing happened all over again. He has been in to see me since he left too.

Now this fellow who is in here now just came in last night. He seems to be a nice person, but he's sort of quiet and I haven't really got to know him yet. He is having his teeth extracted today so maybe he is a little bit worried about the operation. I imagine that he'll be very nice and that the same thing will happen over again if he is here long enough.

Patients thus form two groups—the newcomers who are adjusting to the hospital regime for the first time, and the oldtimers. One of the latter group commented:

I know all of these nurses well. I have been a patient here four times now, and my husband has been here twice. We feel that this is our second home, and hardly mind getting sick and coming to the hospital any more, because everybody here is nice to us. Time passes quickly because we are among friends.

Early ambulation encourages patients to get together, and compensates in part for the shorter stay. The oldtimers give the newcomers advice on hospital personnel and how to adjust to the attitudes and personalities of various nurses. They may have had experience in several hospitals and enjoy making comparisons between them. They explain the hospital regulations and how to make adjustment to the demands made upon the patients. The new patient is helped in this way to fit into hospital routines, when the nurses are too busy to give full explanations, or when procedures have become so routine to them that they fail to realize how puzzling they are to patients.

Miss Sarah Walsh died at forty-four years of age after spending all but eight of them in hospitals. During the last sixteen years of her life she remained in the same ward.

She enjoyed being the Queen Bee on the ward, where she maintained more or less control over other patients. Being here so long and known to so many people, she did have a lot of influence. When a new patient would come into this ward, she would initiate them, tell them what to expect. She was more or less the orienting committee for the newcomers. She was also an inspiration to many because she was so terribly handicapped and yet remained cheerful, attractive and well adjusted.

Because of the need which almost all patients have to believe in the skill, wisdom, and benevolence of those who are caring for them, relationships between patients tend on the whole to re-enforce confidence in the care they are receiving, although at times there may be invidious comparisons between different doctors and nurses.¹ As a rule the patients as a group tend to bring the recalcitrant into line and to encourage one another in carrying out their prescribed regimens.

¹ William Caudill et al., "Social Structure and Interaction Process on a Psychiatric Ward," *American Journal of Orthopsychiatry*, Vol. XXII, No. 2. (Gives an account of the way patients on an open ward re-enforced each others' confidence in their doctors.)

VI. The Role of the Patient in Integrating Hospital Activities

In Chapter I we referred to the fact that a mutual concern for the welfare of sick people on the part of hospital administrators and doctors has made it possible for the two to integrate their activities effectively even though the formal organization between them is a loose one. The patient has a similar integrative effect on the day-to-day operations of the hospital. Partly because of the crisis and uniqueness so characteristic of illness, and partly because of the dual authority of hospital administrators and attending physicians, it is impossible to prescribe invariable routines or completely clear single lines of authority. Ambiguous situations are a feature of the hospital. A high degree of effective cooperation is equally characteristic of it. This is largely due to the fact that all concerned recognize that the patient and his needs are paramount. This book is concerned with the workers within the hospital, but it should be borne in mind that the patient and his illness are a very vital element in the human relationships among those who care for him.

PART TWO

THE HOSPITAL POWER STRUCTURE

INTRODUCTION

IN CHAPTER I, we pointed out that the modern hospital has resulted from a transformation of a very dissimilar medieval institution of the same name. The enlarged resources of scientific medicine created a need for a center where they could be brought together for patient care. The hospital transformed itself from an institution pursuing its own goals according to its own standards and traditions, to one for facilitating the goals of an outside group.

The workers in the old hospital carried on such familiar and commonly understood activities as housekeeping, food preparation, and traditional bedside care similar to that given by relatives in the home. The task of administration was to coordinate these activities. There were few technically abstruse elements in the situation to complicate the work, and hospital administration was essentially like that of other organizations of the time.

In the modern hospital all the activities are directed toward facilitating very complex and highly specialized medical techniques. The greater complexity of hospital operations demands far more skillful administration than in the past. Administration for the most part is in the hands of others than physicians, but the purpose of the hospital administrator is to provide a setting for the doctor in caring for his patients, and administrative decisions are governed by medical considerations. Doctors, on the other hand, for the most part pay little attention to administrative problems or are even scarcely aware that they exist.

The transformation of the hospital has resulted in a unique distribution of authority. The formal organization is not a true picture of the actual exercise of authority. The power of the governing board to

appoint them does not mean that the administrator and the medical staff simply execute policies determined by it. Decisions are arrived at rather through the interaction of these three groups. Though appointment to staff membership is necessary if the physician is to exercise his authority, his power is really derived from his professional training and competence. He speaks on hospital problems, not as a creature of the board but as a member of the medical profession. In many hospitals his appointment by the board is a mere ratification of a recommendation by the members of the medical staff, since it is pretty generally assumed that only his professional colleagues are competent to judge his qualifications.

The administrator is a creature of the board and receives his authority by delegation from them. But he is more fully acquainted with the day-to-day changing problems of the hospital than the board members, who can devote only a small portion of their time to its affairs. They depend on him for information and guidance in making their decisions. As one board president put it:

I am a part-time man directing a full-time man. I can understand how Mr. James [the administrator] gets irritated at this. I don't blame him. It's hard for him.

While it is hard for him, at the same time his detailed knowledge of hospital affairs gives him a leverage through which he can influence board decisions.

Board, administrator, and staff are united in a common interest in adequate patient care, but each has special interests in particular aspects of the hospital activity and each initiates changes related to its special interests. But none of them has complete authority to effect changes. Changes can be carried out only through agreement and cooperation of all three. There are no clear lines that can be drawn to separate the areas of special interest of each. The concern for and the authority exercised in regard to many aspects of hospital administration by the three groups varies widely from one hospital to another and fluctuates from time to time within a single hospital.

Where effective power is divided three ways and where the special concerns of each of the three groups in authority cannot be sharply defined, it is obvious that interpersonal relationships will have a large influence on the decisions arrived at. These interpersonal relationships grow not only as people deal with one another directly on hospital matters but in their interactions in other business situations and social

affairs. The social structure of the community therefore has a definite influence on the human relations and decision-making processes within the hospital.

One aspect of this influence merits particular consideration. The hospital trustees are very largely drawn from the social leaders of the community. They sit together on many boards and move in the same social circles so they learn to know and understand each other well. The leading doctors in the community move in much the same circles also, so the same sort of understanding develops between members of the two groups. The hospital administrator, on the other hand, rarely has either the income or the social prestige to enable him to share in these relationships. His relations with both board members and staff members are largely confined to hospital business where all are constrained by their particular roles. The fuller and more rounded mutual understanding which develops from more varied interactions doesn't have a chance to develop. The administrator can influence the decisions of the hospital triumvirate only through his formal relationships with the other two, whereas doctors and board members can influence one another and come to agreements about hospital policy during their informal contacts.

The main interests of the three groups may be stated as follows: the trustees interest themselves primarily in the over-all policies of the hospital; its financial stability and the impression it makes on the community. As leading citizens they are vitally interested in the hospital's public relations. The administrator, while he shares the view of the trustees to a large extent, is much closer to daily administrative decisions. His concerns revolve usually around such problems as inter-departmental relations and the coordination of diverse working groups. He has to think of all the possible internal effects of policy decisions and interest himself in many details of routine management. Doctors do not have to concern themselves with these details. They look primarily at the technical, medical problems, and do not regard worries about finances or the intricacies of hospital administration as of concern to them. This summary is an exaggeration of course. Doctors, administrators, and trustees look at all these aspects of the hospital, but they differ in the emphasis placed upon them. The hospital does not and cannot mean precisely the same thing to all.

On the other hand, these areas of special interest to the three groups cannot be separated. There is no clear line between general policy decisions and daily administrative decisions. Both types of decisions

can have very important effects on the medical activities in the hospital. And the doctors' decisions can affect both hospital public relations, and the internal problems with which the administrator has to deal. One can't assign decisions in each of the special areas to the group most concerned with it, and leave that group to deal with its problems without regard to the others. All decisions must be integrated with one another and this cannot be brought about in the hospital by a referral up to a final overall authority. An effective integration in the hospital can only be arrived at by mutual understanding and accommodation on the part of all three interested groups.

CHAPTER 4

THE BOARD OF TRUSTEES

THE RESPONSIBILITY of the hospital trustee for the general policy of the institution cannot be understood without some conception of the voluntary nature of the role. The spirit of voluntarism in America has traditionally supported the idea that men can willingly band together for a common purpose without governmental controls. Thus outstanding citizens freely devote time and energy to a nonprofit enterprise from which they can derive no personal gain except community prestige and inner satisfaction. Trustees serve, for the most part, because they are genuinely interested in the quality of hospital care and feel some obligation, as favored members of the society, to give their voluntary service. When a loose association of men governs a complex organization, innumerable problems of authority, specialization, and definition are created. The advantage of such control is that it is responsive to local community interests and preserves the flexibility essential to meet a swiftly changing situation.

Who Are the Trustees?

Trustees are usually chosen from among the more prominent members of the community, and in the hospitals we observed they tended to have attained high status in business or the professions. Representatives of old families with inherited wealth are often found on hospital boards. More recently, however, trustees seem to be chosen more for community influence or unique ability than for social position alone. A businessman who can lend his prestige to fund appeals or policy

decisions is valuable. So is an advertising executive who can contribute expert talents in the field of public relations. The strategic position of a prospective board member in the community at large is generally given first consideration. Does he hold a place from which power can be wielded in the hospital's favor? Is he likely to be able to influence the press, the city government, or the private donors to hospital funds? In one hospital the local newspaper editor and the president of the women's auxiliary of the hospital were elected to the board although neither was wealthy nor conspicuously successful. The editor was chosen because he could arrange favorable treatment to news stories and provide much free publicity through editorials. The president of the auxiliary was chosen because the board thought that her presence would insure liaison between the trustees and the volunteer hospital workers, and add a feminine voice to an otherwise male board.

The vice president of a board in a small hospital explained the membership composition of the board in this way:

I feel the board should include representatives from the top business and professional people and those that can really do something for the hospital. Some people think we should get some boys from the other side of the tracks, but if we did, they would just talk and not *do* anything, because they haven't any influence.

Another board president, after describing his work in fund raising for the hospital and explaining how important a personal chat could be in obtaining a large gift, said:

Our auxiliary does well too. Their main trouble is that they don't ask for *enough* money when they try to raise funds.

Although certain board members recognize the need for bringing the young community leaders in, it is probable that boards tend to be heavily weighted with older citizens because of the qualifications demanded for membership. It takes time to develop into a successful, prominent community leader and in a man's early career he is perhaps too busy getting ahead to occupy himself with public service. Since age and high income tend to be associated with conservatism, it is to be expected that a board of trustees is usually conservative. Many harassed administrators and eager research-minded medical men would agree that one of the functions of the board seems to be to "drag its feet," especially when finances are an issue.

It is not always easy to get good members for the board. The hospital in a small town, especially, may be handicapped by scarcity of citizens qualified for and interested in board service. Many otherwise outstanding people do not have the largeness of view, particularly in fiscal matters, which a board needs if it is to set far-reaching policy.

The composition of a hospital board almost inevitably reflects the characteristics of the surrounding community, since the members are leading products of that setting. A board can be a mirror of community social relationships. It cannot assume a character or set goals which are radically different from those of the city in which it is enmeshed. This is not to say that trustees cannot exercise creative leadership, but the hospital is closely bound up with other institutions and with prevailing patterns of behavior.

Responsibilities

The board holds the hospital in trust. A private voluntary hospital is a gift of private donors to serve a community need. It is the responsibility of the board to provide and maintain an institution which will serve these needs according to the wishes of the donors. It has a responsibility both to the terms of the trust and to the community which the hospital serves. In order that it may fulfill this trust, it must be the ultimate source of authority. Individual trustees differ widely in the amount of responsibility that they exercise. Some attend the board meetings once a year merely to confirm policies which have been determined by others, while some take an active, detailed interest in hospital problems. Boards as a whole also differ from one hospital to another in the degree to which they participate in the formation, as compared to the ratification, of policy.

We pointed out in the introduction to this section that much of the initiative for major policy comes from outside the board itself, because so many choices are grounded on specialized knowledge which the trustees do not have. This seems to be an increasing trend. But because they are in a sense outsiders to the hospital system, they are able and are often called upon to mediate between the goals of competing groups within it. The board's relation to hospital policy can be of three sorts:

- (a) initiation of policy
- (b) transmission of policy
- (c) mediation of policy

(a) There are times when the board must *decide* upon some important change and work to carry it through. Excellent examples occur in the reorganization of smaller hospitals which have fallen on grim days. The major difficulty may be financial, but just as frequently it is an internal disorganization of one sort or another, especially the sort found when the administrator and medical staff are at loggerheads. At one such institution the president described his first steps after being chosen to head the board:

First I fired the superintendent and brought in somebody I thought could do a good job. This place was saddled with debts. There were many months of bills outstanding and some creditors were getting worried about the hospital's ability to pay. The first thing I did was to go down to the bank and borrow \$25,000 to pay off the worst debts. The doctors had been fighting among themselves. There were two factions on the medical staff, and their battles had split the whole town. Our hospital had a bad reputation and the public was beginning to lose confidence so I called the leaders of the factions together—they're both younger than I am—and told them that they would have to get together and end this open warfare. Then I started a fund raising campaign and forced the doctors to contribute first. I told them they were benefiting from the hospital as much as anyone else.

(b) The board may be called upon to transmit policy when an outside agency puts pressure on the hospital to improve its standards or run the risk of losing accreditation.¹ The various accrediting agencies do not actually determine policy but the penalties for losing their stamp of approval are serious for the hospital. The trust imposed upon the board members cannot be fully met if minimum standards are not maintained. The trustees pay attention to these agencies and will fight hard for suggested changes that did not originate with the board.

(c) When a suggested policy change is developed from within the hospital, as it often is, the trustees must monitor the proposal and attempt to resolve divergent aims. One interesting type of conflict involves the relative emphasis to be placed on research on the one hand and regular medical care on the other. Here, although the root of the difference is probably a philosophic disagreement as to the hospital's proper function, it may be brought to the trustees as a technical argu-

¹ Accrediting agencies are voluntary in character. Member hospitals submit to regular inspection as a means of self discipline. In this way, adequate standards are maintained and regular improvements are encouraged.

ment; e.g., whether a particular type of research investigation is feasible. The board must then attempt to choose on information supplied by others. A group of generally informed laymen is thus called upon to decide between technically informed experts.

Relations with the Administrator

In a large industry, the board of directors exerts its authority mainly through a hired president or executive. The situation of the hospital administrator differs from that of the company president in two ways. First, hospital administrators are usually given much less discretionary power than a corporation president. They have been on the whole much more closely tied to the board and its wishes, and consult with it more frequently in decision-making. In the second place, the board of directors of a factory is in a position to delegate to the president authority over all workers, but, as we have pointed out in Chapter IV, the hospital board is not able to delegate effective authority over the doctors.

The board itself occupies a unique position in hospital affairs which sharply distinguishes it from the business situation. While it lacks the proprietary interest of directors who have a financial stake in an organization, there is often a feeling of responsibility exceeding anything found in other enterprises. A hospital board has a keen sense of pressure stemming from responsibility for human life. This makes for difficulty in the delegation of authority, as trustees responsive to patient needs strive eagerly to be certain those needs are met. Reluctant to assign authority in matters which may touch life-or-death, they sometimes become directly involved in hospital operations.

The amount of discretionary power which the board does delegate to the superintendent varies widely. Many administrators feel strongly that the board should limit its activities to the formulation of general policy, but should stop short of detailed supervision in the day-to-day life of the hospital. Yet they express a desire that the board be interested and involved. Perhaps one cannot have deep persistent commitment without inviting occasional "meddling."

The board president whose sympathetic understanding of the difficult position of his hospital superintendent was noted earlier,² when he remarked on how hard it is for a full-time executive to be supervised by part-time trustees, nevertheless said at a later time:

² Introduction to Part Two, p. 36.

Did you notice the color Jenkins [the administrator] put on the front hall? He went right ahead without asking anybody. I should have kicked his pants for it, but I didn't because it's unimportant.

One administrator writes as follows about the general problems:

On the negative side there is something more to expect. I want my trustees to know what not to do. Many of my colleagues dread the interference of trustees in the routine administration of the hospital. This interference is generally conceded to be the greatest single threat to the authority of the administrator.³

A very important feature of the obligation of the board both to the donors and to the public is to insure the permanence of the hospital and its services. This imposes on the board a very clear responsibility for financial management and most people probably think of this first, as the trustees' job. A prominent feature of nearly every report from the hospital administrator or his staff to the board is a balance sheet showing what part each specific department or activity plays in the hospital's economic structure.

The board considers the effect of every proposed policy decision on the financial stability of the institution. If it failed to do so, it would be unfaithful to its trust. This is obvious, but the necessary concern of the board with means is one of the commonest sources of misunderstanding between it and those who are primarily concerned with ends. It should also be pointed out that attention to financial problems of the hospital has its constructive side. Very often it induces the administrator or the medical staff to re-examine certain of their goals and to clarify their own thinking. The board is the great asker of questions in the hospital. Why build a new wing? Why purchase new equipment? Why raise the salary of maids? The close questioning often irritates enthusiastic proponents of an idea, but it can be a safeguard against hasty or ill-examined actions. Furthermore, close attention to the budget is more than a banker's concern for neatly balanced ledgers. The board may use financial management as a means of directing the hospital to certain goals, rather than make it simply an end in itself. Money problems often symbolize underlying cross-purposes in conflicts which seem at first to have little relation to dollars and cents.

Though all boards in discharging their responsibility must concern

³ E. M. Bluestone, M.D., "What I Expect of My Board," *Hospital and Modern Society*, Bachmeyer and Hartman, eds. Cambridge: Harvard University Press.

themselves actively with financial matters, they differ widely in their attitudes toward hospital finances, as the following quotations indicate:

We have developed a research philosophy in this hospital. Our trustees once were very anxious about the balance sheets but they have educated themselves to accept the deficit as the price for intensive research work. They recently expressed remarkable attitude and insight for a group of businessmen. We were considering a candidate for the administrator's position, since I will soon retire. This young fellow came up here and brought with him the books from his current hospital. He was very efficient and very proud of his balanced books. Our board rejected him as a candidate because he showed *too much black ink* in his books. They felt that he couldn't be recording these beautiful surpluses if his hospital were doing all that it *ought* to in the way of medical care and research.

—An administrator

All that board cares about is how much will it cost. They pondered and pondered over the problem of buying a new deep therapy machine. I explained to them that if they bought the equipment and didn't like it they could turn around and sell it at a profit the next day.... Finally they put up the funds. They just can't look ahead of the immediate costs and what a hole it makes in their books. They don't see the long-range value of spending money in certain ways.

—A staff surgeon

Human relations inside the hospital are influenced by the attitude of the top policy-makers toward monetary decisions. In a hospital where the board allowed the administrator fairly wide discretion in the purchase of equipment, nurses spoke in warm terms about how promptly their most urgent needs were met. Little doubt seemed to exist that money policies were well tailored to medical requirements.

Relations with Doctors

The board and the organized medical staff seldom deal with each other directly as formally constituted groups, although liaison committees may be created to act in an advisory capacity, and as we pointed out, informal relations between individual doctors and individual board members often have far-reaching effects on the hospital.

Although it was once common for one or two older physicians to be appointed to the board, both trustees and doctors have come to feel that this practice is generally undesirable. It is held that such an arrangement fosters a possible conflict of interests, since the doctor is himself

subject to the judgment of the board, and his membership on it might give him an undue economic or policy-making advantage. As a noted surgeon put it:

We doctors have no part in management, and I am sure that that is only right. We do plenty of griping about management but it is better that we should not have responsibility in management.

Since the board has little direct authority over the doctors except its power to appoint or refuse to appoint them to the staff and since even this authority is limited in practice, it must to a considerable extent depend on the self regulation of the medical group. However, when this fails the trustees often try to push the doctors toward accepting a new code of standards and practices. Sometimes they try to do so through the administrator, instituting regulations which he is expected to enforce. At times they persuade the medical staff to tighten its own self regulation. Dealings between the trustees and the doctors were greatly facilitated in the hospitals we studied if the medical staff itself was well organized. A board has no effective, established way of exerting pressure unless it can do so through a chief of staff who has definite authority. A board president took note of this in the following comments:

Discussion of cases with our liaison committee usually ends up in a pleasant evening's conversation. The doctors say, "Oh, we'll take care of that," but that's as far as it goes. There is no clear line of responsibility shown. I was asking the staff about a new anesthetic that had been used on a patient who had died on the table. They couldn't give me a good explanation. I feel that if there were a head of surgery appointed by the board of managers, we could go to him and say, "Look, you're responsible for this case, we want to know what happened."

Just as in its relations with the administrator, the line between guidance and meddling by trustees in medical problems cannot be clearly drawn. No one can say just how deeply the trustees should penetrate into medical affairs. The medical staff can often use its special competence as a lever to extend its influence into nonscientific areas and to block trustee investigation. A board president recounted that in discussions with the doctors about economic practices, as in the case of salaried medical specialists, a certain physician always lectured the trustees about interfering with "the sacred doctor-patient relationship."

Yet medical topics are legitimately reserved for those qualified to dis-

cuss them. The dividing line cannot be drawn in advance but must be worked out in give and take between the two groups and this calls for mutual understanding of the other's point of view. But that this understanding is not always complete is shown by the following quotations:

I don't like the way the board always goes so slow. We should have a full-time pathologist, but you have to get them used to the idea gradually. It's the same with equipment. How do you get them to see the medical necessity?

—A doctor

The board must watch expenses. Doctors will buy anything, all sorts of new gadgets, and never care how much it costs. Once they were all excited about those glass boots for stimulating circulation. We bought them, and I'll bet you can still find a few around the hospital, but they were never once used to my knowledge.

—A board president

Many trustees believe they must take a broader view of hospital affairs than doctors can be expected to. These board members tend to see the medical staff as a group of experts whose interests are largely confined to medical matters. The comments of two different board presidents are illustrative:

Doctors you might say are technicians. What we need are not technicians but coordinators. People who bring all the different techniques together. As I see it, that's what the board of managers is supposed to do at the hospital. The first duty of the trustee is to help preserve the patient's identity. Doctors get case-hardened, can't see the patient as an individual.

Our publicity committee has to censor the things doctors say for publication. Doctors will do foolish things in public if you don't watch them.

Relationships within the Board

Trustees vary greatly among themselves. Any single board, despite the common characteristics described earlier, will have members who differ in the interest and the amount of time they devote to the hospital. An "active board" is not necessarily one in which every member digs eagerly into hospital affairs. One board president stressed that certain trustees who don't participate fully should nevertheless be retained:

Some members who don't appear at meetings can still be very important. I know their telephone numbers. I called on a business executive

the other day and before we were through he had given me \$10,000 for the hospital out of a clear sky.

A major problem is age and retirement. Unless individuals are elected for a specific tenure, the board may become weighted with inactive members.

Some of them don't do anything. I'm sure some haven't been inside the hospital for over a year. We have one old lady who has been an invalid for five years, but still hangs on. They stay until they die. I am trying to get some of the dead wood off of the board. We have a committee set up now to ask one member per year to retire.

—A board president

Factionalism may of course interfere with the board's effectiveness. The members, perhaps because of their success in the outside world, tend to be individualists and to hold their opinions with some firmness. The stress which they place on values may diverge at many points. The familiar conflict between financial means and humanitarian objectives which is a source of stress among other hospital people sometimes divides board members as well.

Since trustees have the major task of threshing out a working philosophy for the institution, it is not rare for them to disagree, particularly on the policies to be adopted toward the other two powers, the administrator and medical staff. One board president described his effort to induce the other board members to have chiefs appointed to the medical departments. His board refused to back him in this proposal, arguing that, "We cannot do medicine. You can't get away with that." Similarly we have known boards which debated long and hard the problem of replacing an authoritarian director of nurses with a more democratic one.

Relations with the Public

Trustees are an important link, perhaps the most important, between the hospital and the community. They are normally active in the community and can exercise much influence by explaining the hospital's position on controversial issues such as costs. They (and the patients) are the public within the hospital.

While the trustees represent the public interest, they serve without compensation. This adds weight to their impartial position. However, their very eminence as community leaders, which makes them alert

to certain key values and attitudes, may separate them from the average citizen. The board is in some sense insulated from the currents of mass opinion, and may have to make special attempts to discern that opinion.

Trustees recognize that part of what the board holds in trust is the hospital's reputation and they are usually zealous to preserve its good name. They work toward this end in two ways. First, there is a formal explicit effort to hold public favor. There is often a publicity committee of the board which concentrates on this problem. One such committee was set up under the leadership of an advertising executive and charged with the supervision and censorship of all news releases. It is interesting that in this case the committee began to act only after a premature release of research findings had brought censure to the hospital.

Perhaps more vital than planned effort to promote understanding is the informal influence of the board. Through their day-to-day activities in the community, trustees can learn what the public opinion is and do much to sway influential persons. A casual word dropped by a powerful trustee can often accomplish much more than months of routine work.

The hospital's position and policy have become the object of so much public attention in recent years, and its problems are so enormous, that some board members have nearly a full-time job smoothing public relations. Constant interpretation of the hospital's situation to the surrounding community is essential for both financial support and intelligent public use of hospital resources. Then, too, the growing public awareness of medical standards has made the board more sharply aware of responsibility for explaining those standards, and defending hospital practices in the forum of community opinion. In particular, complaints about the high costs of medical care and anxieties about its quality as compared to the ideal or to standards in other cities have forced trustees to become self-conscious about the relation of hospital to community. Finally, the board has come to protect the hospital against unwarranted pressures of outside groups eager for a policy-making voice.

The success of the board in its public relations has a direct bearing on human relations within the hospital. The employees soon learn the local reputation of the hospital. Their pride and spirit are strongly influenced by what others think of their job. These in turn have a significant effect on their attitudes and relationships to one another.

Summary

The board of trustees is the bridge between the hospital and the local community. Its members are the responsible public guardians of the hospital organization. Beyond their corporate trust in the financial realm, the board members act as general policy-makers. Their degree of supervision over the administration varies, but it is generally agreed that they should not concern themselves with the details of routine management. The division of the responsibility between the two varies widely from one hospital to another. The board deals chiefly with the administrator and the medical staff. In both cases, the relationship poses the fundamental problem of lay versus expert authority. The board members' prestige and formal power in the community are usually at least as great as that of the physician and therefore they are better able than anyone else to maintain a balance between technical scientific claims and other interests. Relations between board, medical staff, and administrator are complex and rest finally on mutual understanding and accommodation rather than formal lines of organization. This triad of human relations affects more than the three top agents. It profoundly influences the internal relations of the hospital as a whole, as well as its ties with the outside world.

THE ADMINISTRATOR

THE PAST TWO DECADES have brought adjustment problems to virtually everybody who works in the hospital. Doctors have had to keep abreast of rapid developments in diagnosis and treatment. Trustees have faced dwindling income and rising costs. Nurses have had to cope with a great influx of patients. Dietitians have struggled to keep up with changing theories in diet and nutrition. Of all the people in the hospital, however, the administrator has probably had greatest need for flexibility in the face of change, for all of these problems have engulfed him to one degree or another. He was the one whose task it was to help all groups encompass the needs of the hour. The speed of change varied from hospital to hospital, and different degrees of emphasis were placed on one or another aspect of development. As a result, the job of administration now shows a wide range, both in the nature of the work to be done and in the type of person employed to do it. We cannot say, "This is what the Administrator is like."

Who Are These Administrators?

A study published in 1948¹ reported the life careers of a thousand American hospital administrators. Within this group were men and women from one hundred and thirty-one different occupational backgrounds. Among them were represented forty-three different levels of education. Clearly there was no approved route toward becoming a hos-

¹ *Hospital Administration: A Life's Profession*. Chicago: American College of Hospital Administrators, 1948.

pital administrator. It had been assumed that any good man could learn the rudiments of the job through experience. A reflection of the way times and opinions have changed may be seen in the fact that today over a dozen major American universities offer courses which lead to a professional degree of Master in Hospital Administration. This has been a development of the last twenty years.

What motivates an individual to enter this field of endeavor? The thousand administrators referred to above reported that the desire for prestige and salary was important to them and what kept them moving from one administrative post to the next. Half of them had made one or more such moves within the six years prior to the study. We found a fuller explanation of work satisfaction in the words of one of the men we interviewed:

I think I like the variety in it most of all. You have a little bit of everything: Medicine [he was a doctor], public health, public relations, legal work, and human relations. Actually the human relations aspects are the most important part of it and what I enjoy most. The things I don't like are the trivialities, things that have no real relation to the job itself. I get to thinking, "For heaven's sake, did I go to college for this?"

John Zugich,² an experienced hospital administrator himself, explained the job-hopping tendencies of his group by the fact that men are measured by the size and prestige of the institution which employs them, therefore an ambitious person must take each opportunity to "advance." Such mobility among jobs is no longer as prevalent as it was even a few years ago. A tendency now exists in the larger hospitals to promote administrative assistants from within the ranks. This places a handicap upon the person who begins his career in a hospital of more modest proportions, restricting his freedom of movement.

Distinctions are sometimes made among applicants for administrative posts according to medical versus business training and again, between men versus women.

Charles Prall³ analyzed the backgrounds and opinions of one hundred administrators, and came out with some interesting comparisons of their perception of major problem areas. Among them were the following:

² John Joseph Zugich, "Influences on Interpersonal Relations in the Hospital Organization." Unpublished M.A. thesis, Yale University, 1951, pp. 31-38.

³ Charles E. Prall, Director, *Problems of Hospital Administration*. Chicago: Physicians' Record Company, 1948.

<i>Problems Reported</i>	55 <i>laymen</i>	22 <i>doctors</i>	14 <i>nurses</i>	8 <i>nuns</i>
Working with the doctors	40%	41%	71%	62%
Improvement of medical care	50%	63%	90%	50%
Business and finances	61%	40%	43%	62%
Community relations	50%	50%	50%	12%
Physical plant and equipment	33%	25%	50%	25%

% stands for the percentage of administrators of each type who reported one or more problems in the given categories. The index for nuns has low statistical reliability because of the small number participating.

(This table is drawn from a larger one which appears in the Prall Study.)

It may be seen that the women administrators reported more difficulty with doctors than did men, and that persons with medical or nursing education were more concerned over medical care than finances, while lay administrators were the reverse. In a field which offers such a variety of facets, it is probably natural for an incumbent to focus on the one in which he is most interested and best informed. The fact that he does so does not necessarily blind him to other factors nor render him inefficient in handling them. It more probably does define his area of greatest usefulness and satisfaction.

The Work of the Administrator

In the past, hospital "superintendents" were hired as custodians of property and equipment. They were expected also to husband the financial resources of their institution, which usually involved at least a modicum of record keeping. In addition they were expected to administer policies and orders of both board members and doctors. At that time it might have been said that custom was the real ruler of the hospital. Things changed slowly and not only the medical and nursing professions but other hospital occupational groups as well, had traditions and habits which governed their on-the-job behavior. New people entering the hospital had to adjust to prevailing ways of doing things.

When the era of great social change began to sweep through the hospital, all of the administrator's tasks were made more complicated. His responsibility for the maintenance of the physical plant, for example, involved more work and intellectual effort on his part as new ma-

chines had to be selected, purchased, installed, and tended. As bed-space became scarce, it was the administrator who had to determine how and where to squeeze three beds in where only two stood before. In addition, virtually every hospital we know about inaugurated a remodelling and rebuilding program to modernize the physical plant. At one time hospital building wasn't too difficult for an amateur to comprehend. Today bulky equipment requires special foundations; x-ray machines and radioactive isotopes demand shielding. Oxygen must be piped in from central storage rather than be carried to the bedside in cylinders. All of these things require expert knowledge on the part of those who do the planning, and the administrator now figures importantly in this process.

As financial problems grew steadily more acute, the administrator soon found that his knowledge of accounting methods and business practices had to be sharpened. Sometimes the pressures on financial resources were so great as to push other concerns from his mind. One harassed man exclaimed,

{ Anything which is brought into this office is translated into terms of one thing, and that's dollars. After all, it is my business to think about the dollars.

The most challenging aspect of the administrative job for some administrators lay in the area of human relations. Subsequent chapters will detail the anxieties and passions which beset the various occupational groups as an old authoritarian order died and newer patterns of relationship grew up which were more in harmony with modern personnel practices. It wasn't an easy time for anybody who had been trained under the vanishing order of things, and sometimes this included the administrator, too.

The psychological strains were intensified by the economic ones. Outside the hospital, wages were rising to unprecedented heights as the war inflation developed. Hospitals, in common with other institutions based upon humanitarian ideals, occasionally fell into the ends-means fallacy. As one observer of human affairs in a cynical mood expressed it:

"The nobler the professed purpose of an organization, the less admirable its personnel policies.

Since the hospital's end function was noble, it sometimes must have seemed that any means to achieve it was therefore justified. The less money spent on wages, the more there was left for charity. The less

time and sympathy spent on employee problems, the more left to devote to patient care.

Hospital employees who were raised in the old traditions accepted their wages and working conditions more readily than did new ones. Under the stress of wartime conditions and the disheartening tempo of change inside the hospital, however, many of the older employees departed and new, and therefore unindoctrinated, workers took their places. It was the administrator who had to deal with dissatisfied employees and overburdened supervisors. One man admitted ruefully that it came to the point where he hardly dared walk down the corridors of his own hospital. Every door he passed brought personnel from one level or another running out to ask him what to do about this or that situation. The rule of custom and tradition was broken as many new employees found themselves surrounded with other new employees, and all of them were uneasy in the rapidly changing situation.

One responsibility which the hospital administrator shares with all other executives may sound paradoxical but is quite real. This is the decision of when to break rules. In a hospital unexpected things are always happening. Hospitals, after all, deal with crises in human affairs. In the smaller hospital in times of tranquillity, custom controlled most situations and standing orders governed most emergencies. Only the administrator had authority to modify those standing orders. As the times grew hectic, more and more of the old rules began to crack. There were too many new employees, for one thing, and too many patients to be easily cared for, and too many unexpected developments for one man to handle alone.

Some administrators adjusted to this situation more easily than others. One man, and there is reason to believe he was not unique, tried to deal with it by promulgating a new general order whenever a crisis occurred, and each order was intended to cover all similar cases in the future. Scattered about through this hospital were clip boards on which these standing orders had accumulated until they were four inches deep. Any reasonably shrewd worker who found that a decision of his had unfortunate consequences, could manage to locate somewhere in the pile an order which would authorize what he had done.

Other administrators, realizing that they couldn't be everywhere at once, began to delegate some decision-making power to their most trusted subordinates. Standing orders grew more general and depart-

ment heads were trained to know which crises they could safely handle themselves and which must be referred to their superior. This decentralization of authority is discussed more fully in later chapters.

It may sound as if the administrator's life was all grief, and some people apparently found it so at this time. A few men just threw up their hands and let things fall into chaos, or gave opportunity for more strong-minded subordinates to take over the reins of authority. In one case known to us it was the director of nurses who assumed the responsibility. A succeeding administrator told us:

Now there was a character for you. When I came in here she was running this place practically single-handed. She had the whole thing under her thumb. You see, the man who was here before me was a different kind of fellow. He was very able, too; it wasn't a lack of ability. He was just lazy, I guess. Anyway whenever anybody wanted him he was out fishing. She didn't think much of him and neither did the Board of Managers for that matter. She had gradually elbowed him out and controlled the hospital.

In other instances the superintendent (now an outdated term for administrator) hung grimly to what power he had and went on hoping that the good old days of peace and quiet would return. There remained that portion of administrators who did not give up, who were challenged rather than defeated by events. By straining every capacity such men were able to keep abreast of the times. It was men such as these who worked to keep their trustees up to date too, persuading them where and how the hospital would have to modify its course in order to cope with new situations. As they exerted pressure upon the institution to bring it abreast of the times, their prestige rose. They were seen to be "successful administrators" in comparatively well functioning organizations, as compared to other situations where chaos mounted.

An important source of strength the hospital administrator found during these years of stress, lay in his contact with his professional organizations. In meetings and institutes held by regional hospital councils and national professional organizations, he found opportunity to talk over his problems with other administrators and to compare possible methods of solution. When his responsibilities grew at his place of work, he turned more and more to these associations for assistance in improving his own qualifications for his growing job. Today the

administrator, like the doctor, the nurse, the laboratory specialist, and the professional dietitian, sets his goals not only according to the wishes and demands of his immediate superiors and staff, but in the light of the best opinion and developing professional standards of his occupational peers.

Relations Between Administrators ✓

The difficulties involved in coordinating an increasingly larger and more restless organization led in some places to the hiring of administrative assistants. This trend was encouraged by the professional hospital organizations as a way of training potential administrators. Whether the assistant was a young fledgling or an older experienced person from within the organization, the problem soon arose as to how his work could be distinguished from that of his chief. Should he attempt to duplicate the administrator's role, sharing his power and taking over half of his duties of all varieties? Should he rather be restricted to those chores which his chief found most irksome? Or should a division of duties be made such as medical vs. nonmedical administration; physical maintenance of the plant vs. the coordination of people, or even a geographical division with each man taking over half of the buildings? We saw several types of accommodation and most of them appeared to be working out well enough where the two men shared each other's full confidence and could get together easily to talk over their work. It may be seen, however, that any of these divisions could also aggravate an organizational split if the combination of personalities was an unfortunate one.

What is more, even where a careful delineation of duties was made, informal understandings and relationships acted to bend the tidy scheme out of shape. For instance, in one hospital the chief administrator and his assistant assured us solemnly that they shared exactly the same duties. This was their original intent and evidently both believed that it had been carried out in fact. Our observation and interviewing within the hospital led us to believe that something different existed. One of these men was a doctor and it was to him that the medical staff came with its problems. The other man, having a business background, was apparently found more approachable by the members of the nonhealing occupations. In addition to this, one of the men was quick to act, a vigorous and decisive force who was respected for his ability to master crisis situations. The other was slower moving and

by nature a listener. All through the hospital we were told by employees that they picked their man accordingly:

When I want action, I go to Baylor. When I want to cry on somebody's shoulder, I go to Wallace.

The two men thought their duties were about the same, but it may be seen that the organization interpreted their roles differently.

We found that the spontaneous creation of an informal counselor such as Mr. Wallace was not uncommon in organizations going through a period of stress. Usually it was just such a person as he, close enough to the top to be helpful but not so close as to be awe-inspiring. Sometimes it was an administrative assistant, sometimes a nurse supervisor, sometimes a highly respected secretary. The more adjustments people were being called upon to make, the busier they kept such a counselor at his listening post.

Mr. Baylor and Mr. Wallace had been working together for years and any initial difficulties in accommodating their personalities had long since been forgotten. In other hospitals the position of assistantship was still new. While they were naturally reluctant to be quoted, it was evident that such assistants were experiencing occasional hesitations, a feeling of groping in the dark, while the jurisdiction of their work was being carved out. It may be seen that this takes time and patience, for it is not just a question of two men adjusting to each other but of an entire organization accustoming itself to the areas of authority which each administrator will cover.

The interpersonal relationship between the two men sometimes was complicated by a differential in their background. As in industry, an engineer whose wealth of knowledge is based primarily on experience may be nonplused to find himself with an assistant who has a professional degree, so an administrator who learned his work apprenticeship style may be disconcerted to find himself with an assistant who has a Master's degree. It is the same problem that many head nurses are facing, as changing educational requirements bring in student nurses who have already graduated from college, or senior laboratory technicians who face juniors with graduate degrees in bacteriology. The pattern is repeated throughout the hospital. There is always potential strain in such relationships. The only certain eradication of it is the gradual acquisition of a thoroughgoing respect based upon the experience of working together on shared problems, and this takes time.

The Administrator, the Trustee, and the Doctor

The way an administrator regards his board and medical staff may be seen more clearly through case history material than through mere description. Life can be infinitely richer and more subtle than we can portray it.

One administrator told us that when he started working at the hospital a decade earlier, his board was holding its regular monthly meetings at the most fashionable club in town. Some of them hadn't set foot inside the hospital for years. This club was composed exclusively of the most prominent citizens and included among its members were top-ranking physicians and surgeons. Not only did the board hold its meetings there, but some of its members ate their noon meal there fairly regularly as well and thus associated with the doctors in easy, informal contacts. Younger and less successful doctors were not invited to join this club, and couldn't have afforded to anyway, any more than could the administrator. He always referred to it as "that damn club."

You know, they meet downtown at that damn club and discuss hospital affairs. Sometimes if a doctor wants something and I won't get it for him, he corners a board member down at the club and talks him into getting it. Then the board member phones me and orders me to do this or that. Maybe when I explain my point of view, he will be sorry he let the doctor talk him into something, but he can't very well back out of it.

In other words, the board and leading doctors were forming decisions without the administrator and by the time the news reached him, it was often too late for him to do anything more than accept them. By dint of persuasion, the administrator succeeded in coaxing his board to meet at the hospital instead of the club. They began to do this occasionally, and at length it became routine. Meanwhile the administrator was cultivating their interest in the daily affairs of the hospital. He telephoned at least six of them every day, he told us, explaining his philosophy this way:

The way I see it, the administrator's job is to find out what each trustee wants from the hospital, what his dream of the hospital is, and then to help realize that dream. I feel that my trustees really know what is going on around here and take a deep personal interest in it.

The board
to meet the



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however, was that some of them became involved to the point of interfering at many trivial places. And even with such close contact as he achieved, the administrator continued to be irked by the fact that the doctors obviously had more power to move the board than he did. Incidents arose which indicated clearly that hospital employees were also aware of this differential power. When they couldn't get what they wanted from him, they went over his head to the medical staff and through them to the board. The doctors didn't hesitate to stand up to the board when some policy decision displeased them. The administrator didn't dare to. It would have endangered his hard-won intimacy. His relationship with them continued to be strictly that of subordinate to his superiors, rather than one of working partner.

This man was at least beginning to approach the place where he could challenge the power of his medical staff. Consider the plight of the person who cannot do even that. In some institutions a woman who has been successively a student nurse, head nurse, and director of nurses all in the same hospital, will sometimes be promoted to the responsibility of administrator. How is she to exert authority over those who have been her superiors for so long? In some instances she succeeds in doing so quite well, through quiet persistence and skillful diplomacy. In other cases she may not even attempt to do so but takes for granted that the wisdom of the medical staff is never to be questioned at all but that her major task is to carry out doctors' orders and to keep them happy at all costs. What may have been suitable behavior in her position as nurse, can be devastating in her role as administrator.

In one situation we heard about, medical and surgical standards within the hospital had allegedly slipped below the level of adequacy to the point where the hospital was threatened with the loss of its accreditation. The board of trustees which had always accorded the doctors every freedom, now decided that sterner measures had to be taken. Their first attempt to correct the situation consisted of an effort to use the administrator's office as a disciplinary agency, whereupon their nurse-administrator resigned. Interviewed later at another hospital, she had this to say:

The doctors there were losing face, they were just losing face, and I couldn't see that. That isn't in accordance with the way I was trained. We were taught that the doctor-patient relationship came before every-

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thing else. After all, the doctor and the patient are the guests of the hospital. Now that board of managers couldn't see that at all. They thought the doctor was getting a privilege to be allowed to work there. You can't treat doctors the way they wanted me to and not have it hurt the doctor-patient relationship.

It is apparent, regardless of the merits of her arguments, that this administrator was not the person to bring pressure to bear within that situation. Her whole training and philosophy precluded her from attempting to control the medical staff, or even from exerting influence over their work habits. When she and the board did nothing, it was up to the medical staff to discipline its own members. For a long time they had done so effectively. In the course of time, however, things evidently got out of hand and when the medical staff failed to hold the brakes, standard of operation began to go downhill.

It is, of course, no easy matter to re-establish discipline in an ongoing institution. Tensions are certain to arise but there is no way for trustees to escape their common responsibility for acting on their own best judgment to preserve and defend the good of their institution and the well being of its patients.

Sometimes bringing in a new administrator may seem to promise a way out of a bad situation, but then getting him accepted presents its own chain of problems. If he has sufficient strength to stand against pressure and to make changes, the balance of power within the hospital may shift in a way which brings protests from the medical staff. They may begin to perceive him as encroaching upon their rights. One board president remarked:

The doctors' main gripe is the administrator. You see, they always had things their own way. The former administrators gave the doctors just about anything they wanted. Now with this man, he is a professionally trained person. That's what I keep *hammering* at them! He has had just as much professional training as they have had themselves, but they can't see it. They don't know how to take him.

One wonders whether it wasn't precisely his professional status which made him so difficult for them to accept. On the one hand, it required an adjustment on the doctor's part to a changed relationship. On the other, it is always possible that this professional administrator group sometimes pushes too hard for the status it feels necessary to have. Who can say where the proper point of balance lies?

Unquestionably the administrator of today requires a higher status

and more authority than in the past. Not only is his role within the hospital more crucial as the institution itself becomes more complex, but he is being called upon to exert leadership within the community as well. He, as well as board members, is being called upon to make public appearances, explaining hospital needs to civic groups and enlisting their support. If he is to do the work required of him, he must be able to command an equivalent amount of respect for his position. To give him that status sometimes requires work on the part of the trustees, for it represents a series of shifts in relationships within their institution.

When tensions become too much to bear, it may help to recall the calm wisdom of Florence Nightingale about the benefits of a division of power and the cleansing effect of healthy differences of opinion. In her day the big issue was the tension between the nursing orders and lay authorities.

Great have been the "scrimmages" from time to time between administration and the Orders: and great have been the benefits to the sick from such scrimmages. . . . Now the balance is most happily established. The administration complains of the Sisters, and the doctors wish the Sisters were "completely under them." The Sisters complain of the administration and wish that the Order had it completely under itself. And all are the best possible friends, and the collision and competition does the greatest possible good. And all work much better for it, and none know how much evil it prevents, how much good it secures.⁴

Fortunately most doctor-administrator relationships are not of such serious import. More often they are pleasant and innocuous, marked with the joking banter which is so typical of many hospital relationships. The joke is probably the best antidote to tension, and hospital people make ample use of it. The experienced administrator frequently acts as close friend to new medical students and interns, not to mention struggling young doctors. It is often he who teaches them how to get along with other hospital personnel, arbitrates their disputes, helps to cover up their occasional misadventures.

When a doctor does create organizational problems, of course, the administrator finds himself in the middle between the warring factions. Since the doctor is not part of the formal organization, it is hard to call him to task. The greater his reputation, the more difficult it is to handle a crisis which he may create. For example:

⁴ Florence Nightingale, *Notes on Hospitals*. New York: Longmans, 1863, p. 181.

ADMINISTRATOR:

We have been having trouble with Dr. Gardiner again, have you heard? He called the telephone operator a dumb bunny and now he has been so rude to one of the nurses that she quit. Well, I talked to him last night and he was adamant on the subject, said he *had* to act that way, that he isn't himself if he acts any other way. How do you like that? He says that's the way he gets what he wants and he always has done it that way. I guess he figures it's his privilege to be a tyrant. That man pushes everybody around.

INTERVIEWER:

Do I understand there really isn't any way to control a doctor's behavior?

ADMINISTRATOR:

Oh, I wouldn't say that. There is control over everybody really, but you might say that the doctor is under the least of any of us. He can get away with more, especially if he is good. When you get an excellent man like this one, you don't like to lose him and the trouble is, he knows it. If he was poor in his work, it would be a different matter.

In this particular instance, the administrator finally handled the problem by getting a physician of even higher repute to counsel the man.

All of the hospitals studied had medical staff committees to deal with disciplinary matters. Their job was to see that medical records were kept up to date, that medical practices remained up to standards set by the group, and so on. So long as these staff committees were effective, life ran smoothly. When they fell into disuse, the administrator sometimes faced a difficult task in convincing individual doctors that their hospital privileges would be taken away unless they met the policy requirements.

We saw several instances where a board or hospital administrator called for help from some official body such as the American College of Surgeons or one of the hospital associations. One administrator stated:

For my part I would rather handle such things from an educational level than from a level of individuals. In my opinion, by having this outsider come in and talk to us as a group, the relations of the whole staff have improved in a way that I couldn't possibly have accomplished by talking to an individual doctor in my office. Occasionally, of course, I do have

the duty of taking one person to task but then generally it is on a very specific and usually minor matter.

In his relations to the medical staff, the administrator needs and commonly seeks the support of his board, and since he was chosen by the board to supervise the hospital it is reasonable to expect that they will stand behind him. But both this expectation and the fact that it is not always fulfilled are cogently demonstrated in an article entitled "Support Him or Fire Him."⁵

We don't want to imply that the superintendent's life is a constant struggle against encroachments by his board and the medical staff. Each group has a clear dependency upon the other two, and with rare exceptions the people whom we interviewed had a genuine respect for the contributions of members of the other two groups. Their mutual understanding wasn't always as deep as their good will, however, and when disruptive actions occurred the administrator suffered. Dr. Bluestone expressed this feeling as follows:⁶

The upper millstone consisting of the governing board and the lower millstone consisting of the working staff must grind out the finest product that can contribute to the health of the community. The administrator must never allow himself to be permitted to be caught between these two forces. It is for him to see that the interaction between these two parts is as perfect as human beings can make it, but he must have safeguards to protect him from injury in handling such delicate yet cumbersome machinery.

Relations with Hospital Personnel

The relations of the man at the top with his department heads and the problems he may encounter in getting harmonious interdepartmental relations are matters complex enough to require a chapter of their own. Something should be said here, however, to indicate the subtle, all-pervasive influence the administrator's personality has upon the employees as a total group.

It has already been mentioned that in a complex organization such as the modern hospital, a certain portion of decisions must of necessity be left to the judgment of those closest to the particular situation. The administrator must rely upon the competence of the various professional groups. In the hospital, four things are of paramount importance:

⁵ Paul Gordon, "Support Him or Fire Him," *The Modern Hospital*, 1953.

⁶ E. M. Bluestone, M.D., *op. cit.*

technical skill, humanitarian purpose, flexibility, and organization. The administration is responsible for providing all four. People with the necessary technical skills must be selected and hired and the way made easy for them to adjust to the requirements of their work. Their various activities must be effectively coordinated, and at the same time there must be sufficient freedom left for them to exercise their own professional judgment.

When flexibility runs out, it is the administrator who must supply it. It is he who provides the grease when friction begins to burn out the bearings, who gives direction when other human beings involved get themselves in a tangle. The influence of a wise and calm individual in this post may be seen by considering what happens when he is called out of town. One very able young assistant administrator told us this tale with a wry smile.

The administrator had no sooner gotten out the front door than the whole hospital seemed to crumble under my feet. It always seems to happen that way. The first thing that happened was that one of the patient's visitors fell down the stairs and fractured her thumb. That always creates a lot of excitement because people are worried about the hospital being sued. I think we got that taken care of all right. Then the procession started of individuals coming to my office with complaints. None of them were serious, you understand. For instance, I remember that one of them was that the meat for the patients was being sliced too thin. Now it seems silly, looking back on it, but you know how those things are. The person was so upset at the time that the problem seemed insurmountable. By eight o'clock in the evening I was still working and completely worn out. It wasn't that I had accomplished anything, it was just all these petty details and complaints. I hadn't done any work but I was exhausted. I went to my room and fell into a deep sleep but I no sooner got asleep than the phone rang and somebody told me that the record room was on fire.

The emergencies vary from day to day but some things persist. In addition to keeping the organization on an even keel, it is the administrator who, more than any other single person, sets the tone of relationships and attitudes. We saw both positive and negative examples of this. One resident physician remarked:

A person is always afraid of being jumped on. You know, "What are you going to do about that patient in the ward? He doesn't have any money, you better get him out of here. How about the patient on the third floor? Don't you think we'd better move him down to the ward,

he doesn't have very much money." You know, that spirit seeps through to every member of the staff. You might say that the materialism at the top of the hierarchy affects all the rest of the employees including the nurses and the medical staff. They get into the frame of mind where they feel because a patient doesn't have any money, he isn't entitled to good service. It's just the attitude they get and it seems to permeate the entire hospital.

In other cases, while top administration was certainly very concerned about finances, the focus of attention was quite obviously on the satisfaction of human needs and again, the example was set at the top and followed, more or less faithfully right on down the line. These things are difficult to measure, to state in cause and effect terms. It was never a matter of preaching that seemed to work, but the more subtle influence of example and a pervading philosophy of life.

The tone of personnel relationships was set by the administrator too. The word "unwitting" seems too strong, yet the process did not seem to be one which was logically arrived at but appeared to happen spontaneously and to be imitated, also spontaneously. There is a contagion in human relationships. For example, in one hospital we found a group of orderlies who were unusually stable in their jobs. What is more, our interviews were replete with compliments concerning them. The head orderly explained it to us this way:

There is a nice spirit at this hospital and it comes right down from the top. Have you noticed that? Mr. Simons is not high hat at all. If he goes down the hall and sees a new orderly there, he'll go over and make himself known to the man and say good morning and how are you and express an interest in his work. He makes that man feel as much a part of this institution as Mr. Simons is himself. Well, the other people around here see that, don't they? That sets the example.

The thing which caught our attention was the fact that Mr. Simons, in this situation, had plenty of help. He was not working alone but as part of a team. Peter, the head orderly, was a man of unusual character and dignity and it was he, as well as Mr. Simons, who established the precedent of respecting the job of the orderly, a group which is much disparaged in many hospitals. Neither man might have succeeded alone in setting such a pattern, nor could both of them together do it without the cooperation of the entire body of orderlies who struggled to live up to the reputation they gradually came to acquire. But who put Peter in the job of head orderly? It was our observation

that throughout this hospital, it was people like Peter who were promoted, who received encouragement. You can't command the humanitarian spirit, you can only recognize it and cherish it when it appears. It is the administrator who decides whom to place in key positions and it is the key people who set the tone for their departments.

How One Hospital Changed with the Times

The history of developments and change in one hospital may illustrate many of the points which have been discussed in this chapter concerning the way an administrator influences and is influenced by a total situation. This was a city hospital which had a close association with a medical school. Both hospital and school were venerable institutions with reputations for being among the best in their part of the continent. The board was composed of leading citizens. It employed a superintendent to carry out their wishes. Board decisions were influenced to some degree by "top flight doctors," which is to say men who were widely recognized in their community for professional skill, large practices, and good reputations. The concern of the board, medical staff, and administrator was to continue the excellent reputation of the hospital in that city. The local community, it might be said, was the standard against which they measured themselves and their achievements.

As times changed, the hospital prospered outwardly, growing in size and in the number of its patients and employees. The administrator added an assistant. However, in the meanwhile developments in medical education elsewhere were beginning to place this hospital at a disadvantage. The rise of heavily endowed metropolitan medical centers staffed by full time faculty members with national reputations, made it increasingly difficult to attract students and interns to a school and hospital where private practitioners with only local reputations continued to teach in their spare time.

When the hospital authorities became aware that even the sons of its most prominent doctors were going elsewhere for training, they faced a crisis. The hospital had to rise to meet the competition it was receiving from medical centers elsewhere, or else accept a permanent second class position. Many other hospitals may have faced a similar situation with less in resources for meeting it. This one was not poor but like other hospitals it had many other financial drains upon it at this time. Nevertheless it decided to accept the challenge. The decision was made to hire full-time staff men with international reputations based upon

scientific publications and leadership. These men were given the task of reorganizing the teaching and research programs. To interest them and to hold their continuing loyalty, the hospital had to offer them joint hospital-university appointments and to allow them full freedom to do research and teaching as they saw fit.

The presence of these men changed relationships in many parts of the hospital in very subtle but pervasive ways. There was no formal or legal change. The board and its administrator still had unquestioned authority to make and enforce policy decisions. But one does not tell a man internationally respected for research what he is to do. One discusses with him possible alternatives and welcomes his participation in making decisions. More day-to-day freedom was accorded these new department heads than had been given in the past, and more people had effective voice in decisions than before.

Mary Parker Follett discussed this phenomenon years ago, as it began to occur in industry.⁷ She made the distinction between "position authority," that which stemmed from position in a hierarchy, and "functional authority," that stemming from ability to do a piece of work. In this hospital the distribution of power became modified. Authority became increasingly functional, with considerable range for autonomy within their own fields being permitted for those of recognized competence.

The medical staff, some of whom had approved this series of innovations and some of whom had not, began to be caught up in the after-effects. There was a quickening of professional growth throughout the staff. The doctors were also aware that the medical field was advancing by strides and that to maintain status they would have to put forth effort to keep up and to achieve recognition for competency from their own professional associations. It might be said that the total environment was stimulating individuals to grow while, in turn, these individuals by growing helped to stimulate each other, thus increasing the tempo of total change. There was a period of almost universal striving on the part of individuals and groups.

The administrators were in the forefront of all these developments, smoothing the way for them and struggling to keep abreast of change too. Here were men who found the crises of wartime exciting rather than defeating. They relished the struggle and soon became leaders in their own professional organizations encouraging the pooling of knowl-

⁷ See *Dynamic Administration: The Collected Papers of Mary Parker Follett*, ed. by H. C. Metcalf and L. Urwick. New York: Harper & Brothers, 1940.

edge and techniques among administrators from all over the nation. In other words, just as the doctors were becoming specialists, so were they. They kept pace.

What would have happened to them if they hadn't continued to grow? Would they have been able to coordinate effectively their increasingly alert and ambitious staff? As it was, the board, the administration, and the medical staff were growing and changing all at the same time and in so doing, kept and renewed the respect they held for one another. No one group could afford to shrug off the opinions of another, for all were of recognized competence in their own area.

It should by no means be assumed that human relations in this hospital were entirely comfortable. Probably there were just as many problems as in any other institution, but to the outsider it appeared that a feeling of accomplishment underlay the ebb and flow of daily events. People were too busy to fret much about changes in personal advantage from one week to the next. Each was hard at work, growing with the institution. There was a common pride both in their individual progress and in belonging to an organization that was recognized by all as increasing in esteem both locally and nationally.

Summary

In the early days of the industrial revolution, factories frequently had "work superintendents" whose function corresponded roughly to that of the hospital superintendent of years ago. Such men were given the responsibility for supervising the work of rank and file employees. Professional employees such as chemists or engineers, however, seldom carried their problems to him. When they wanted something done they typically went directly to the plant owner. The owner-manager and the professional would talk things over, reach a decision, and then inform the works superintendent what their agreement was and leave it to him to see it through. As industry grew larger, and small owner-operated plants were replaced by giant combines, the owner-managers disappeared to be replaced with boards of directors who, in turn, gave over the administration to their full-time representative, now called a president or executive director. The engineer, chemist, and the physicist soon learned that they could not approach the board directly but had to route their communications through the executive if they wanted to get something accomplished.

Something similar has been happening in hospitals. Boards of trustees typically have found themselves confronted (a) by a rapidly expand-

ing organization; and (b) by much more intense public relations problems than before. Mounting pressures inside the hospital encouraged them to delegate increasing authority to their full-time representative, the administrator, and to leave to him the task of coordinating the steadily growing numbers of professional as well as nonprofessional people who worked there. This process is not so extreme as in industry, as other chapters have pointed out, but a parallel development may be seen.

The administrator today has responsibilities so complex that he must have expert knowledge in many fields in order to cope with them effectively. When he acquires such knowledge, he gains respect and stature in his relationship with his board and medical staff and frequently is given considerably more room to exert personal initiative than in the past. At the same time, the scope for initiative of his subordinates has also increased. They too have become expert in more complex tasks and require a greater degree of freedom in meeting their professional responsibilities. The administrator therefore has had to develop new skills as coordinator, a more subtle form of leadership in place of the direct authority he may have exerted in the past.

CHAPTER 6

THE MEDICAL STAFF

Who Are the Doctors?

PHYSICIANS ENJOY EXTREMELY high prestige in American society. The doctor is a model of professional achievement, in that he embraces altruistic service, a self-determined ethical code, independence, highly specialized training and above-average material rewards. His services are the more highly valued because he functions in an area of very critical importance to his client. The role of lawyer, professor, or engineer, however skilled he may be, does not have the dramatic immediacy of the doctor's, nor does his client depend on him in the same degree. The individual's faith in his physician is partly emotional, since illness makes men less able to judge and more apt to lean on professional resources in an uncritical spirit. And we are coming to understand that faith in the doctor is a necessary element in cure, that he will not be able to exercise therapeutic leverage if we as patients regard him in too prosaic a light.

The medical profession, because it offers high prestige and income for engaging in intrinsically satisfying work, is able to attract talented individuals. Some of the best college graduates go on to medical school. Competition for entrance to medical schools is so keen that the schools are free to pick only the most competent students. The long and difficult course of training, from premedical studies through a hospital residency, results in an extremely skilled individual. Today's physician is not only a well-qualified professional when he begins his career, but if he is really competent his professional growth is lifelong. The rapid

pace of medical development means he must be an eternal student, that he can never rest on finished mastery of his art.

In a highly organized society like our own, the specialist enjoys a unique prestige. The medical specialist is an expert among experts. He can develop his knowledge and technique to a high pitch of excellence, concentrating on those things of greatest interest to him. He can offer very superior care to patients whose difficulties lie within his competence. Yet the immense advantages of specialization have carried certain potential hazards. One difficulty is that the practitioner does not really have time to treat the whole patient, and this counters the growing recognition of the seamless fabric of mental and physical illness. Another negative feature of this elaborate division of labor is seen in the barriers to communication and understanding within the profession. In recent years, however, one can begin to distinguish a movement back toward more unified medical practice. Men whose goal is general practice are being graduated in larger numbers. The internist is coming to act as family physician and referring agent; most important, the whole man and the whole family appear to be gaining acceptance as the most coherent units of illness.

Qualities of ambition, dedication, and independence are obviously required of the men and women who become and remain doctors. Since their position is exposed to unusual strains and special demands, it is not surprising that they should be impatient and rebellious, at times, toward the organizational framework in which so much of their activity takes place. Yet the smooth running of that organization, the hospital, rests to a very great extent on the coordination of doctors' activities into a group effort. An examination of the doctor's role supports the conclusion that his often-remarked failure to fit perfectly into the hospital system is rooted more in the peculiar demands of his training and function than in personal characteristics.

The doctor's function has traditionally involved very grave responsibility for his patient's welfare. Obviously, heavy responsibility calls for appropriately great authority. Recent legal rulings have tended to enlarge the hospital's responsibility for patients but the distribution of liability is ill defined and varies from case to case. Power and responsibility, and the relation of the two, continue to complicate the mutual adjustment of hospital and physician.

Problems which arise in the doctor's hospital participation, to be treated in more detail later in this chapter, center around his individualism and desire for dominance or independent control of his situa-

tion. The qualities of ambition and self-reliance so necessary to the person gaining an M.D., and so respected and appreciated by patients, may become less desirable in the context of a hospital team. But it is probably impossible for the doctor to renounce the very drives which made him a successful student. Throughout his training he has been subordinate to those on higher rungs of the medical ladder, has been taught to pay close attention to status. In the hospital, as a staff member, it is unlikely that he will willingly give up much of the authority and prestige he has finally gained. Similarly, he has long realized that he is judged on his singular technical ability, his professional competence. Therefore the sharing of rewards and responsibility which marks successful group effort may not be wholly congenial to him.

Since the especially intense relation of doctor to patient imposes responsibility on the physician, he naturally cherishes the freedom of action which he thinks necessary to meet that responsibility. He develops a strong need to be untrammelled, and this need is sometimes frustrated in the hospital environment, where many individuals are restricted in their rights and duties in the interest of orderly coordination. Communication between the doctor and patient is unbalanced; although the patient must recite his symptoms and history, it is the physician who speaks in tones of knowledge and authority. The doctor is expected to dominate this situation. Yet his hospital duties increasingly involve him in coöperative relationships where the accent of authority must be modulated.

If clinical diagnosis and creative surgery confirm the impression of medicine as an art, the battery of techniques and mass of verified knowledge also characterize medicine as a science. This complicated art-science holds much genuine pleasure for the practitioner. The artist's joy in discovery, the scientist's thrill in research, the man of action's deep satisfaction with concrete practical accomplishments—all these are potential rewards for the doctor. Medicine, however, has such stature as a field that the public harries it with overexpectations. Patients expect their problems to be solved, and doctors themselves, in expressing the fundamentally American belief that answers ought to be available, may sometimes foster too high a level of anticipation. Therefore a feeling of intense disappointment may accompany any ineffective medical work regardless of the realistic factors in the situation. The job is laden with possibilities of psychic strain; defense against an overinvolved sympathy with patients often takes the form of a protective callousness or cynicism, which may be misinterpreted

by the layman as a sign that the doctor "doesn't care" when in fact it may be a defense against caring too much.

Training is long for the physician. Specialists today average thirty to thirty-five years of age at the time they begin their careers. The period of schooling has lengthened considerably as new knowledge is acquired. This means that the person is an apprentice, with a subsidiary place in the medical system, for the first twelve to fifteen years of his adult life.

The extremely rapid progress of medicine also imposes another stress upon the practitioner. As in most professions, the obligation to keep pace with advances in knowledge and techniques is a pressing one. One hears many anxious comments from doctors who know that they should keep up but seldom find time to do so. This explanation (self-justification) seems typical:

I just don't have time to read. I'm working eighteen hours a day now, and am exhausted after evening office hours. When I do get a day off, I feel I should take the chance to go fishing or play golf. Last night at eleven o'clock, I finally looked at my pile of journals. I only had time to count them, and there were thirty-seven back issues.

During the long training period economic gains have been slender or nonexistent and indebtedness is often heavy. Now at last there is an opportunity, as the professional career begins, to earn rather large amounts of money. Of course the doctor is not the only one who strives for a high income, large car, and pleasant neighborhood. But the doctor starts late and sometimes feels that the time to build a secure fortune is perilously short. A senior resident in a large Eastern hospital expressed the case this way:

It has cost my father about \$28,000 to get me to my present position, including medical school fees and living expenses. Not only have I lost all this, but one should add to it the loss of what could have been earned during all these years. If you compare that with a high-school classmate who has been earning steadily for the past twelve or thirteen years, I have a long way to go to catch up. I could step out of this hospital tomorrow and earn \$30,000 a year, but I only have a few years to do it in.

The feeling that time presses is further aggravated by the belief, based in part realistically on the fast pace of work, that the practicing physician has an unusually short life expectancy.

It is probably fair to characterize the physician as individualistic, ambitious, and resentful of controls over his professional activities, and at the same time humane, intelligent, and hard-working. Though these generalizations cannot be expected to fit every individual of such a diverse group, on the whole this is the sort of man who must be fitted into the cooperative enterprise of hospital care.

Responsibilities

The doctor has one overriding responsibility: to provide the best possible medical care for his patients. Of course some physicians' primary allegiance is to research, and a few are engaged in administration, but the focus of the medical staff is patient care. The obligation is moral and legal, and other considerations must be subordinate to it. While other persons, nurses and trustees for instance, share the responsibility, it always devolves first on the doctor. He commands the course of therapy and makes the basic decisions.

Responsibilities of the medical staff to the hospital grow out of the cardinal obligation to the patient. Hospital requirements with respect to surgical procedures, drug use, and a multitude of other specific activities are designed to protect the patient. Yet these regulations do not always coincide with the individual physician's freedom of choice. He may chafe under restrictions which he feels are inappropriate to a specialist who exerts firm internal controls on his own course of action. The staff is supposed to insure that its members adhere to hospital rules, to take the responsibility for group self-discipline. The fact that it does not always succeed is a recurrent problem of staff organization and staff relation to the larger system of the hospital.

Responsibilities beyond patient care are not as well recognized. One about which some contemporary doctors feel keenly is the imperative to do research. Particularly in large teaching centers, there is the opinion that a physician owes his profession some attempt to increase medical knowledge. Research interests may obviously conflict with other hospital aims, such as budget-balancing. The idea that research may be a responsibility is often a hard one for practitioners, administrators, and trustees to accept, since its relation to patient welfare, though demonstrable in the long run, is sometimes not immediately clear.

One of the interesting paradoxes in the relation of doctor to hospital is that while both proclaim the primacy of patient care their different perspectives sometimes lead to disputes about this very re-

sponsibility. Disputes arise in departments like admissions, laboratories, and surgery; they typically concern timing of work and the distribution of scarce resources. Perhaps a clue to the paradox is that the hospital is concerned with the needs of all the patients, while the individual doctor must feel a first devotion to his particular cases.

The Staff Organization

Doctors are bound to one another not only by the natural solidarity of colleagues but by the knowledge that patients' faith demands a united front of medical competence. They recognize too, that medicine and surgery are today so complicated that the single physician cannot master more than a segment of the total field; he must depend on colleagues for technical advice. Since the doctor bears extremely heavy responsibility for his patients, it is obvious that he often needs the friendly support or reassurance of a colleague as much as he needs strictly medical discussion.

Although there is thus a basic fellowship among medical men, the hospital setting calls for a more formal association. This association takes the form of a staff designed to represent doctors in their relations with the administrator, trustees, and hospital departments. The staff has many functions: it insures adequate coverage of patient load, delegates individual responsibility, regulates standards of practice, including surgical operations and the qualifications to perform them, carries on the education of internes and residents, and recommends appointments of doctors to staff membership.

The internal composition of the medical staff varies from hospital to hospital. It is far more specialized in the large teaching hospital than in the smaller institutions. In any case, there are gradations between older, veteran doctors and those who have recently attained professional status. In a small hospital the induction of the newcomer to the staff organization is largely informal; the newcomer gradually learns the way doctors are expected to behave, the normal attitudes toward others in the hospital such as nurses, and the prestige enjoyed by various staff members.

In the larger hospital there is a definite pyramid of roles and positions so that each doctor may be immediately placed in relation to every other. Chiefs of staff and of services are at the top of the hierarchy, where they can oversee the work of their specialties, initiating and regulating the medical and surgical services of the hospital. Some teaching hospitals have full-time chiefs who engage in little or no

private practice, devoting their efforts to staff supervision, teaching, and research. Chiefs are appointed for medicine and surgery, the two broad divisions of medical activity, and in large institutions there is further subdivision into such specialties as obstetrics, pediatrics, etc., with a chief for each specialty. Below the chiefs are found the great bulk of the staff, the attending physicians and surgeons who use the hospital for their patients. Although members of this attending staff often contribute heavily to the hospital by teaching and service in the outpatient clinic, they are primarily devoted to private practice. The house staff, which owes its allegiance to the hospital itself, includes the chief residents and the very important apprentices in the medical system, the internes and residents. This latter group, while in training, plays a vital part in the functioning of the institution. Under supervision, it provides a very great deal of the total patient care offered by the hospital. It is itself organized in a ladder from the head resident, a highly skilled doctor about to enter practice, to the interne fresh from medical school.

The hospital administrator can consult his chief of surgery, and be quite sure that the decision reached will be understood and enforced further down the line. In the smaller institution there is no extended hierarchy of competence and staff rank, but doctors are roughly on one level. This may encourage the development of warmly informal relationships among staff doctors, but it provides less formal control and discipline than the hierarchy of the big hospital. Incompetent surgery may be speedily discovered under the hierarchical system, although even when discovered and censored necessary discipline does not always follow; in the small hospital control of quality is much more difficult. *The chief of staff in a small hospital complained:*

Look at it from the doctors' standpoint. How would you like it if another doctor who was your equal and a competitor looked over your charts and found mistakes and went around telling the patients that you weren't a very good surgeon, that they should come to him instead. That just doesn't work. Not in a small town and in a hospital this size. *These ideas come from the big cities, and the men here are trying to impose them on a small hospital and it just doesn't fit.*

The speaker was obviously discussing a hypothetical example, which would be a damaging course of action for the profession and the hospital if it were to occur. A usual procedure on the discovery of such information would be consultation with the executive committee of

the attending staff, the administrator, and possibly in due time the board of trustees.

Divisions of interest are bound to arise in all staffs. If these remain at the level of technical differences of opinion (as seen for instance in the traditional split between physicians and surgeons) they may actually increase the possibilities of rich and rewarding discussion. However, divisions may be very disruptive. Even if differing philosophies of medical practice are fought out inside the staff, the conflict may spread to the rest of the organization. The most disastrous divisions for the welfare of the hospital arise from competition for patients and personality clashes. Once factions arise, staff discipline is likely to dissolve and the administrator and nurses are forced to take sides. In one small community, staff factionalism grew so violent that the local citizenry also took up positions, with the result that the public relations of the hospital declined very seriously. Of course the major problems involve others than the medical staff and decisions cannot be reached by it alone. But if the doctors disagree among themselves, their dealings with other powers—the trustees and the administrator—are much more difficult. Professional quarrels among doctors are particularly harmful also because they shake public confidence in the medical profession. Professional associations attempt to keep differences on a private basis and to do their own policing.

Internes and Residents

One of the most interesting of all staff functions is the teaching of young doctors. This teaching, carried on for the most part in an apprentice-master framework, gives the hospital the air of a university. And so, in part, it is, with the medical school employing the hospital as a living classroom. Staff relationships—for the internes and residents are recognized and vital members of the house staff—are perhaps at their best in this area. The eagerness of students keeps medicine fresh and exciting for all staff members; their zest enlivens staff conferences and challenges older practitioners to be at top form. A specialist in any field, it seems, is flattered and intrigued at the idea of passing on his knowledge. Internes and residents gain much from the hospital, both in information and more subtle cues on how to behave as a professional. Their major gain is undoubtedly the total experience of acting out the role "doctor" under extremely realistic conditions. The inspiration found in working with top-flight physicians and surgeons often pushes them to high achievements in their own careers. But if

the young house staff member owes his core professional initiation to the hospital, it must be remembered that he gives the institution an incredible amount of time and energy. He is also often called on for a great deal of service for doctors, a service that may at times conflict with his goals as a student.

The relation of internes and residents to the hospital is a complicated one. In addition to the skills learned and the experience accumulated, the interne derives a certain prestige-by-association from the hospital if it is a major teaching center. He may come to be labeled as a "— man," and take on portions of the institution's renown. The highest-ranked teaching hospitals are able to attract the cream of medical-school graduating classes. In return for his training, the interne serves the hospital as a round-the-clock staff member; he works in many departments, supervised by the chiefs of service and by attending doctors. The ladder of authority has many rungs, so that the young doctor finds himself coached and judged by persons directly above him. Internes, for instance, are under the direct guidance of assistant residents, who are subordinate to the head resident in their specialty; the head resident in turn reports to his chief of service. The interne has traditionally received little or no pay beyond basic maintenance. Today the competition among hospitals for first-rate house staff leads to the practice, in many institutions, of making more than token payments to internes and residents.

Since the interne's status in the hospital is an ambiguous one—part student, part staff member, part donor of services—his relations to other staff members and other hospital employees are often rather ill-defined. Although he is at the bottom of the staff pyramid, he is already intensively trained and is soon to become a full-fledged specialist. One might say that his real status is a latent one. His relations with nurses are generally good and rewarding. More and more, internes and nurses work as partners. The interne is not old enough or experienced enough to dominate the nurse, even though he may "show off" from time to time. The typically warm, often light and humorous, bond between them is strengthened by the fact that an alert nurse may save the beginning doctor from serious mistakes.

Hospital administrators lean heavily on the younger staff members to cover the various facilities, particularly those with very uneven work flow such as the outpatient clinic and emergency surgery. Internes are under the administrator's formal authority as temporary employees of the hospital. Yet their basic direction stems from the medical staff,

and in some sense they are guests as well as employees. Just as in his dealings with the medical staff as a whole, the administrator must elicit voluntary, informal cooperation from his internes. Although there is a set of minimum rules to which the house staff adheres, internes and residents take a fairly independent view of hospital regulations. They are young and spirited, just freed from the grind of medical school; coercion does not impress them much, so they must be interested in doing a superior job. The young doctor's allegiance to his profession is usually great enough to guarantee that he will fulfill his major obligations in patient care, even when he flouts certain minor details of hospital procedure. A chief of surgery spoke of the interne's key role:

It's not like those steel-working laddies, you know. [A reference to a strike occurring at the time of the interview.] If our internes walked out in the morning we'd have to close the hospital by noon... and by three o'clock we would have martial law.

Relations between the younger house staff and the remainder of the medical staff are marked by a tenor of professional respect. Despite the many potential areas of conflict involving methods of patient care and responsibility, our observations tend to emphasize harmony in this relationship. Able senior men take great pride in the proficiency of their students, and try to give them ample opportunity for guided diagnosis and treatment. Yet one of the recurrent problems, touched upon later in the chapter under the discussion of research, and again briefly in the description of the operating room, concerns the nature and amount of work available to the younger house staff. There are often protests from the residents that they lack enough of the right kind of practice, while they are overburdened with routine cases. One surgical resident complained of a certain doctor:

He'll get you up at any time of the night for one of his cases. He just uses the house staff to do his work.

Generally speaking, however, the ties between internes and older physicians are quite congenial, a model for the fraternity of colleagues which the interne is about to enter.

Specialization

As knowledge increases and techniques multiply, a professional field tends to become divided into a large number of specialties. This is a

natural development when the range of detailed competence grows too large for a single individual to master. It occurs in many disciplines and types of activity, but it is especially pronounced in medicine. While all professions are aware of the problems created by specialization, and of the need for combining special viewpoints into a coherent picture of the whole subject matter, medicine is particularly concerned since its subject is the indivisible human being. Failures of communication among physicists, for instance, may retard the development of the science, but similar failure among specialists attending a patient may impair his treatment. There is a critical need, then, both for broadly trained individuals who can correlate the efforts of several specialists with reference to a specific case (a role increasingly assigned to the internist) and for patterns of communication which can effect certain common understandings among the specialists themselves.

The specialist's relation to his colleagues, patients, and the hospital is not yet fully established. His role varies in place and time, and the coordination of his efforts with those of others entails difficult questions of adjustment and definition. The auxiliary specialist in the hospital—the pathologist, radiologist, or anesthesiologist—has an essentially facilitating role in patient care. Problems of economic reward and medical jurisdiction inevitably arise, because these facilitating doctors are in an ambiguous position with respect to patients and regular attending staff physicians. As in so many situations inside and outside the medical world, the technical excellence of the specialist's work has not always been matched by a correspondingly excellent adaptation in human relations. The hospital faces a continuing challenge in making the best use of the specialist's expert skills; his contributions must not only be accepted by the attending men, but must also be woven into the fabric of hospital organization.

The auxiliary specialist's facilitating role in treatment becomes a leading role in research and teaching. Freed to some extent from what Harvey Cushing termed "the killing routine of the clinic," his energy can sometimes be directed to the pursuit of exact information and the elaboration of new ideas. Much notable research comes from the specialist, and it is not uncommon to find him playing a major part in the subtle and detailed discussions which often occur during grand rounds. As teacher, the pathologist and radiologist have a dual function: they instruct students and colleagues in the exact subject matter, and perhaps more important they indicate the ways in which the specialty may be used to advantage by physicians who are not them-

selves expert in its complex detailed operations. Thus specialists try to foster the attitudes of cooperation which may compensate for the barriers raised by intensive subdivision of the field of medicine.

Relations with Patients

There is a growing sophistication in medical matters among the general public that makes patients question doctors more closely and demand more explanation than in the past.¹ At the time when medicine has greater resources than ever before, patients are also better informed and educated so that fewer things are accepted on faith; furthermore, other hospital workers do not seem to hold the physician in as much awe as his patient does.

The medical staff is in a sense the recruiting agency for the hospital; except for charity and accident cases, patients enter the hospital on their doctor's recommendation. And once inside, the doctor is the link between the patient and the strange world of the hospital on the one hand and the world he has left on the other. The doctor is thus in a strategic position to interpret the hospital system to the patient and to bring information to the hospital administration about patients' attitudes, criticisms, and satisfactions. He may be able to persuade the recalcitrant patient to accept hospital routines; on the other hand it can be frustrating for a nurse to work hard over a patient who then talks only about his "wonderful" doctor, hanging onto his every word and taking the nurse for granted.

Patients are not only problems of individual care for the physician but make a very important contribution to research and medical progress. A nonpaying case with intriguing symptoms often gets more attention and draws far more intellectual effort than a wealthy person with a routine ailment. In the large hospital, teachers, students, and research men have a direct interest in the numbers and types of cases admitted; they sometimes press for bed space to be devoted to interesting charity cases rather than mundane pay patients. In a hospital which handles both private cases and patients unable to pay, a conflict of goals may easily arise. Several residents in one large general hospital expressed the belief that their training suffered because of the scarcity of charity cases and felt the hospital should accept more patients of deep clinical interest, if necessary at some financial loss.

¹ The *Reader's Digest* recently announced that it would send advance copies of medical articles to doctors, so they might be prepared to discuss the newest drugs and techniques with their patients.

While the patient undoubtedly benefits from increased attention which research possibilities bring about, he may decide that he is being used as a "guinea pig," that the doctors are more interested in his symptoms than in his cure. And he may feel under strain from being on "exhibition" when a chief of service comes to his bed trailing students behind him and delivers a public commentary on his condition, or when he is subjected to many repetitive examinations and is asked to relate his history to several different medical neophytes. In general, however, patients appear proud and pleased to be the focus of so much interest. They enjoy the unique importance their case assumes in the eyes of the doctors.

Relations with the Administrator and Board of Trustees

Although the hospital administers many services, from emergency treatment to laboratory diagnosis, the responsibility for each patient's course of therapy lies with his own physician. The hospital can do much for any patient in the way of rest, diet, and minor medication, but the critical decisions of medical and surgical therapy must be made by a physician. In a curious sense, unmatched by any other organization, the hospital entertains the most important actors in the medical drama, the doctor and his patient, without being in direct command of either.

The physician's position as at once a guest and the dominant figure in the treatment of patients imposes a very complicated system of authority on the hospital. There are, in effect, two parallel lines of command; one for general hospital affairs, with the administrator and board of trustees at the top, and one for medical treatment, with the individual doctor and the medical staff at the top. In the case of any particular patient, his own doctor's decision is controlling, yet the administrator is charged with supervising the hospital organization in such a way as to facilitate the treatment of all the patients. The hospital, then, has to cope with a highly independent body of experts who are only in a small way subject to administrative direction. Observance of sterile techniques, scheduling of operations and admissions, regulation of the quality of surgery, a host of situations bring out the basic dilemma: who is the boss? How can an organization encompass a group of professionals who are not integrated into the administrative pattern?

Although the trustees are in fact the governing power of the hospital and have an effective veto over staff activities, the doctors have prestige

and technical competence which board members cannot disregard. If the staff does not approve and cooperate, it is almost certain that a hospital policy will fail. Where there are difficulties in determining general policy in the hospital, they usually result from differences of perspective on the part of the staff, the trustees and the administrator.

Some quotations illustrate a few of the problems involved in their relationships:

The relations between board of trustees, the administrator and the medical staff in the hospital are very vague.

We have to keep a close watch on expenditures. I suppose I'm an old tightwad, but I like to check on every nickel that's spent. Doctors love gadgets, and always want to buy them right away. I try to quash their purchases of unnecessary equipment.

The Board has to protect the hospital's reputation. Publicity about a research paper was let out by one of our doctors, and because the research made false claims, everything was in a mess. Now the Board has a publicity committee to check over what is released as news about the hospital.

—A board president

The trustees don't move fast enough for me. The main trouble is that they don't understand medicine. I don't know when we'll get rid of dead wood, and have some trustees who are really interested enough to keep informed about medical matters.

—A chief of medicine

You can't fight the doctors. If you try to browbeat them, you will soon become an ex-administrator. What you must do is get their cooperation in making changes you both want. You have to make them think your proposals were their own ideas.

—An administrator

The first duty of a trustee is to remember the human element of hospital work. Doctors get calloused and forget that patients are human beings.

—A trustee

The organized medical staff is a vital mechanism in hospital communications. Doctors, especially attending men, are seldom in the hospital as a group. They visit briefly and at various times and their attention is so focused on their patients that it is difficult to get their attention for any length of time for nonmedical affairs. At the regular

meetings of the staff, information is passed on in two ways: the doctors' opinions go to the board and the administrator, and messages from the board and administrator go to the medical group as a whole. When the staff organization is working well, it focuses medical attention and summarizes the will of the doctors to other policy makers. An active staff with alert leadership can play a leading hospital role; lacking a coherent staff organization, doctors as diffuse individuals cannot exert a very systematic pressure. It is also to the advantage of the administrator and trustees to have a stable medical organization since it provides much more dependable information about the consensus of medical opinion. Individuals speak only for themselves. In some hospitals a liaison committee of medical staff members sits in with the trustees and vice versa so communication is further smoothed. If the difference in perspective of the top policy groups is substantial, mutual understanding may still result from the exchange of points of view.

The highly independent attitude which is characteristic of most physicians, and their feeling that administrative patterns should be built around medical practice, results in many problems for the administrator in his effort to coordinate the activities of all groups caring for the sick. To a person involved in a technical, highly skilled pursuit, it is perhaps inevitable that what he sees as the "petty" details of organization appear minor and irksome. Ideally the self-regulation of the medical staff should and often does insure compliance with hospital rules, but often the administrator is forced to act because the staff is laggard.

A problem of this sort which seems to be almost universal in hospitals is that of keeping medical records up to date. The hospital must compile a full report on each patient's hospital stay, course of treatment, diagnosis, etc. This is essential not only in legal matters and in controlling standards, but to the doctors themselves as material for research and teaching.² One of the chief tasks of the record librarian or administrator is to induce the medical staff to complete these records. A busy physician or surgeon often puts off his responsibility here, feeling it is less important than his work in actively treating patients. There is no easy way to bring about compliance. Threats and

² An outstanding orthopedic surgeon in a city with a leading teaching center, when preparing a paper on bone tuberculosis, wrote to the state department of health asking for figures on the incidence of the disease. Before replying to this letter, the director had a search made for cases reported by the inquirer and found that he had never reported a case. The director pointed out to the surgeon that with such poor cooperation the figures could not be regarded as valid.

cajolery do a little, but unfinished charts pile up. In one hospital records were piled on chairs around the office waiting for doctors to finish them. In another instance, the librarian sought to push the physicians into doing the job by posting lists of those who were delinquent; she even tried to put pressure on them through their wives by mentioning how far behind their husbands were with their records. In another case medical records were kept up to date with what seemed to be a minimum of trouble. In this instance the medical staff had recommended that delinquents were to have their hospital privileges suspended until the records were brought up to date, and the trustees had requested the administrator to enforce this rule.

The problem of records is only one example of the points of strain which occur as a result of the peculiar administrative control of the hospital. Though there are many such difficulties and irritations, they are not as crippling to the organization as might at first appear. The necessity of voluntary coordination means that the rules under which the doctors act must by and large be created or endorsed by their group. Compliance is more willingly given if the rules have been previously endorsed by those subject to them. The whole situation points up the importance of two elements which lie outside any administrative blueprint:

1. The subtle and unannounced patterns of informal controls. Here we find the tacit approval or disapproval of colleagues, nurses or administrators bearing heavy weight. In addition, the individual's own understanding of what is proper behavior, a "professional conscience," tends to insure that the individual will act ethically. Though the degree of internal self-control varies from one doctor to another, the stability of medical and hospital systems depends on the fact that most doctors censor themselves fairly severely.
2. The changing, growing patterns of human relations among the people involved. Through experience and close association, doctors, trustees, and administrators learn one another's peculiar strengths and weaknesses. They tend to reach some form of adjustment. Since they have to work together, they usually find a way of doing so. And behind their divergent points of view, they share many goals and values. They are members of the same society, they are dedicated to the welfare of the patient, and they are agreed that health is an important goal. The elements binding them together are more powerful than those dividing them.

Relations with Nurses

One of the most striking differences in the point of view of nurses and doctors toward the hospital is focused on the relative part the institution plays in their lives. The nurse's world is the hospital. The doctor's world, on the other hand, is only partly the hospital, for much of his professional time is spent in the community or his office. The doctor uses the institution as a facility while the nurse is employed by it and subject to its administration. The doctor prescribes treatment and thus initiates many of the nurse's activities. She assists him and does those things for the patient for which she is qualified. She is traditionally the doctor's helper and takes directions from him. The nurse has had to struggle to attain a respected position in the hospital and in society at large, while the doctor's prestige is legendary. The fact that most doctors are men and most nurses are women probably reinforces the difference in status.³ The tradition that the nurse is a helpmate to the doctor in a deferential, quasi-servant capacity is still in the background of the doctor-nurse relationship although the situation is changing, and a more nearly equal relationship than existed in the past is developing. At least two signs of this are visible. First, the outward forms of deference on the nurse's part have become fewer and more subtle. Second, many of the menial duties which characterized the nurse's inferior position are being taken over by nurse's aides and practical nurses. The doctor is a working partner to the nurse as well as an authority. The nurse is with the patients for long hours. The doctor's visits to the patients are brief but he gives directions which govern much of what she does during her hours with the patient. Most of the initiative comes from the doctor and his behavior generally sets the tone of their relationship, but it is not as one-sided as might appear at first glance. Nurses have informal techniques of controlling the doctor even though he overtly holds sway. Not only may they use personal tactics such as joking, but by the way they carry out actual work duties they can express their feelings and make the doctor's work harder or easier. Furthermore, they band together as a group more readily than the medical staff. Any doctor soon acquires

³ That the interplay between sex and occupational prestige is a complicated one is indicated by the fact that male nurses generally enjoy considerably less prestige than female. A woman interne in a quarrel with a nurse said to her, "Well, I don't see why any girl wants to study nursing anyway." The nurse replied, "Why it seems very natural to me for a girl to study nursing, but I don't understand why she should study medicine. That's like being a male nurse."

a hospital-wide reputation, and nurses have been known to shrewdly "gang up" on a doctor who had offended one of them:

If things upset him when working with a nurse, the wise doctor will take no action. You never win with a nurse. Sooner or later she can always get back at you, particularly by spreading a bad reputation about you around the hospital. It is easy to get a bad name by offending just one nurse, and I've seen it happen. It happened to me at another hospital. Therefore I do not get into controversies with nurses if I can help it.

—A senior resident

There is a well-established feeling among nurses that one has to "kid a doctor along." Although not all doctors respond favorably to such treatment, it is safe to say that a joking relationship does often act to ease the strains inherent in any system of authority.

But it would be a serious error to think of the relationship between nurse and doctor as an antagonistic struggle for power. There are many possibilities for camaraderie and informal cooperation. And when harmony is achieved, both of them and of course the patients are greatly rewarded. A new generation of young doctors and "emancipated" nurses is slowly evolving a relationship which differs greatly from the master-servant one. They see themselves as fellow professionals, each with a distinctive competence.⁴ The greater knowledge and more rigorous training of the physician make him the leader in the relationship. But the obvious requirements of the case itself, the patient's needs, can often dictate the course of action, lessening need of orders and obedience, giving more opportunity for a shared task. The doctor leans on the nurse's reports of the patient's condition in formulating the course of treatment, while she depends upon him for general guidance.

Since doctors and nurses vary among themselves in personality, skill and experience, different doctors treat nurses in a variety of ways and the same is true of nurses' attitudes. For instance, an older nurse may unobtrusively guide a young interne, taking the lead despite the

⁴ The traditional attitude of the physician toward the nurse is shown in an ancient Hindu medical code: "The physician, the patient, the medicine and the nurse are the four legs of medicine upon which the cure depends. When three of these are as they should be, then by their aid, the exertions of the fourth, the physician, are of effect and he can cure disease in a short time. But without the physician, the other three are useless even when they are as they should be. But a good physician can cure a patient alone just as a pilot can steer a boat to land without sailors."

fact that their positions are formally reversed. Again, nurses' behavior toward an individual physician will be affected by their judgment of his competency. The recognized medical specialist will command a large degree of respect, regardless of his personal characteristics. On the other hand, a less competent doctor who is adept in his interpersonal behavior cannot always fool the nurse. Admiration is usually solidly grounded. Conversely, doctors will lean more heavily on the experienced nurse than on the recent graduate. One of the thrills of nursing as reported by an operating-room nurse is the moment when expert surgeons recognize the nurse as a wholly competent individual, accepting her into their confidence as a team mate.

In general, it seems certain that the social distance between doctors and nurses, as well as between doctors and other professional workers in the hospital, is steadily decreasing.

Research

Research costs a hospital money even though the workers' salaries may be paid by outside agencies. But at the same time it brings prestige to the hospital, not only in the eyes of patients, but in the attitudes of the larger community. The house staff so necessary for effective work can best be attracted when high-caliber investigation is a feature of the hospital. The intensity of interest in research stimulates the zeal of the medical staff and may have profound effects throughout the hospital; it may mean reorienting an entire generation of trustees to the importance of giving financial and moral support to research activities. It can also have a potent influence on morale throughout the organization if lay employees become infected with the spirit of high competence and scientific integrity. This means policy-makers must shift from thinking of the hospital as a refuge for the indigent and regard it as an institution of many purposes. The doctors who entered the hospital as guests to perform a few selected tasks have helped inspire this new concept, that the hospital has a threefold purpose: patient care, teaching, and research. The medical staff may push the hospital to be something more than a "hotel for sick people," a phrase used by one surgeon in urging an administrator toward greater research efforts.

A research program also has a cohesive effect. It serves to draw the medical staff and administration closer together. Pride in the investigation has a way of spreading throughout an entire institution; an

administrator or trustee may be recompensed for some of his trials with medical "prima donnas" if they produce scientific advances.

The Doctor as a Community Figure

The practicing physician finds it ever harder to live a fully developed life of community participation. This is partly because of the distribution of doctors, especially in rural areas, and partly because patient care is a much more complicated technique than in the past. His prestige is high, and his name appears on innumerable lists of committees or sponsors, but he has little time for active participation. The time he once gave to local affairs of a nonprofessional type must now be given to a crushing patient load and, if possible, reading and study. An interesting illustration of the change from a rounded communal involvement toward the harried life of a technical specialist was reported in a small town:

The father, Dr. Larkin, had done all the doctoring in this town for many years. In addition, he directed the Y.M.C.A., was a bank director, and served as Republican chairman of the county for twenty years.

The son, also a physician in the same community, reports that he is going to leave soon to take a residency in anesthesiology. He has become completely exhausted in this town, working eighteen hours a day or longer; handling fifty to one hundred people a day in his office, he feels he can't do justice to any of them.

Specialization also tends to narrow the doctor's over-all participation in community affairs. He sees so many patients that he hasn't time to explore their family backgrounds nor is it likely that he often treats more than one member of a family. Thus what was once the role of family counselor and local man of wisdom, who was consulted for many problems outside of health, has become a more fragmentary technical task. However, re-emphasis on the concept of psychosomatic illness, and recognition of the necessity to treat the whole man or to consider the family as the unit of illness, may draw the physician once again more closely into the web of community existence.

In the broad field of social and economic problems, medical men often appear to lack interest and shy away from positive programs. It sometimes seems that the doctor is reluctant to consider wider social problems because his acknowledged competence does not extend this far. At a recent meeting of several thousand doctors in New York

City, less than fifty appeared for the panel discussion on social and economic problems. As a surgeon explained:

I can only spare time for three or four professional meetings a year. When I do attend, I stick to the medical discussions and exhibits. I haven't the time or the interest for these "political sessions."

While the social position of medicine in the United States falls outside the scope of this study, it is worth emphasizing that the individual doctor tends to cling to his technical role and to neglect the questions of policy on which that role ultimately rests. There are no specific unquestionable remedies for economic dislocation, no infallible laboratory tests for problems of public opinion, and the specialist accustomed to precise answers often finds this realm unwieldy or repugnant. A curious contradiction seems to exist, in that the doctors who foster daily revolutions in methods of treatment are in general quite conservative and wary of social change. While this may be partially explained as the natural conservatism of an economically rewarding profession, the resistance also seems to be related to the single-mindedness of a highly trained technical expert. It is as if the role of "doctor" sometimes bulked so large as to crowd out or overwhelm the role of "citizen," a trend that, in this specialized society, is by no means confined to medicine.

The hospital and the medical staff impinge upon one another at every point. Each sustains each and it is vital to the survival of the other. The mutual involvement is so decisive that it is unrealistic to speak of separate groups. We must think of the situation, "the doctor in the hospital," rather than a pair of forces, "the doctor *and* or *versus* the hospital."

PART THREE

A STUDY OF SOME HOSPITAL OCCUPATIONAL GROUPS

CHAPTER 7

THE NURSING PROFESSION: A STUDY OF CHANGE

ANY SINGLE OCCUPATIONAL group, when studied carefully, may be seen to reflect its total environment and in particular the influences brought to bear upon it by other occupational groups with which it is associated. Nurses have been directly affected by changes occurring within the medical profession, for example. Their work has been modified also by the vastly increased numbers of patients. It is the number and rapidity of changes which has discouraged some nurses. One such woman was about to retire from her profession, and expressed her feelings this way:

Now in the old days, every family had its own doctor and next to the minister, he was the closest friend the family had. They believed in him absolutely and when you got sick and he came and held your hand as your friend, it meant something to you. Now that has gone. It has all gone. Now people shop around for doctors. They have one this week and another next. And the nursing profession has gone down the same way. The nurses are no longer interested in giving service. They don't know how to give good bedside care any more. It's a lost art. There are so many things that enter into it. I don't mean to say that it is anybody's fault, you understand. I think it has something to do with all these new drugs and with this early ambulation too, and everybody having insurance and so many people coming to the hospital that the nurses are worked to death. I think all those things are involved in it. All I can say is, it has changed and it has become worse. A person like

me just can't adjust to it any more, that's all, we can't accept the situation. You try to live with it as best you can, but you don't like it and you can't really accept it. In fact you wouldn't want to.

{ Q. You feel that the relation between the nurse and the patient has become degraded?

Yes, that's exactly how I feel. It has become degraded all the way through and the patients aren't getting the care they used to, and it doesn't mean the same thing to the patient or the nurse or the doctor. It just doesn't mean the same things.

The pangs which she was experiencing were felt by many others. Indeed, her cry was duplicated everywhere we went, but where she and many others were defeated by the changing times, some nurses were stimulated and excited by them.

For the sake of clarity, this chapter will not try to deal with all of the changes which were influencing the life of the nurse. We shall restrict our attention, for the most part, to the internal problems of the profession and leave it to the reader to keep in mind that in reality the nurse does not stand alone but in addition to mastering the problems unique to her group, must also cope with those pressing in from the outside.

In order to get a perspective on the nursing group as it is today it may help to see it as it was in about 1900. There are many accounts of what the life of the nurse was like in the "good old days." The Fiftieth Anniversary Number of the *American Journal of Nursing* contains several of them. Annie Warburton Goodrich drew a vivid picture:

The hospital—well planned for law and order and control. The wards were eighty feet long and thirty feet wide, with ten beds on either side and a medicine chest in the center. How beautiful we thought those wards, especially at night—the rare mosaic tiles, the shining black beds with the red blankets at the foot, illumined by bright lights.¹

She told of how the entire nursing service at the New York Hospital School of Nursing was carried on by students with just two exceptions, the Superintendent of Nurses and a Night Supervisor.

Ruth Sleeper, in the same issue, speaks of "inspection day" in those times as being a flurry of housekeeping with shutters being dusted and seldom-used equipment washed, laundry folded with scrupulous care, and everything put into readiness for the exacting eye of the resident

¹ *American Journal of Nursing*, Anniversary Number, October 1950, p. 598.

physician who surveyed ward housekeeping with military precision. The student nurses were older than those of today, averaging around twenty-five, and their training was mostly an on-the-job apprenticeship supplemented with occasional lectures by the medical staff at odd hours when they could be slipped in most conveniently to the doctor. It was "learning by doing."

How wonderful, the speed one could acquire without the loss of fine technic, grace of motion and dignity of pace.... There were great women in those days who gave physically, mentally and financially, not only to build our profession, but also to open the eyes of society... to its social responsibilities.²

That is the picture which the older nurses remember with nostalgia; one of law and order and control, and one of austere beauty. They remember the dignity and grace, both spiritual and physical, which they saw exhibited and which they sincerely desired to attain for themselves. What they have forgotten, or at least do not tell, is the price that was paid for these attainments. What was it really like for the human being, the high-spirited youngster who found herself in an atmosphere characterized by "military precision"? With but one supervisor on duty at a time, the discipline of students had to be strict. Each entering class had to be taught obedience to the class ahead of it, a stern line of command holding the least experienced in check. To use the language of modern personnel administration, there was "one-way communication"—from the top down! Not only was the chain of authority rigidly maintained within the nursing group, but each student was taught unquestioning obedience to the physician. In addition to these strains, the nurses were cloistered in their own separate residence and visits home were severely restricted since it was the philosophy of the day that they had to be weaned from their families and the sooner the better. The true nurse, it was held, was one who offered her life in devotion to her patients, and extraneous activities were a drain on her energy and attention. She worked long hours and did all but the heaviest cleaning on the great wards. Talk of wages was discouraged as unworthy of women whose proper role was one of sacrificial devotion to the common good.

We did not have opportunity to interview very many people old enough to remember what nurses' training was like at the turn of the century. Perhaps the average girl in those days adjusted to the situation

² Annie Warburton Goodrich, *op. cit.*

without too many pangs. The bitterness which we heard expressed came from nurses who trained in the 1920's and 1930's for the most part and perhaps reflected a post-Victorian period when older supervisors were still struggling to maintain outmoded patterns in the face of a new and unsympathetic generation.

Among the nursing departments we studied were some where the change from old-style to new-style authority patterns occurred most recently. The sentiments which we found reflected there were expressed by one nurse in her middle thirties:

The old supervisor was strict, oh my. We really learned a lot from her. But you know, everything was tight here then.

Q. Tight?

Yes, I mean you had to do everything just right. Even the human relations were tight. Everything was like that, whether it was your technique or your relations with people, it had to be done exactly according to form. It wasn't enough to drape your patients, they had to be draped exactly so, or you had to drape them all over again. Same thing with linens, each towel had to be placed exactly on top of others of the same kind and folded just the proper way, or the supervisor would make you tear the whole closet apart and do it over. A lot of that was foolishness. We never got away from here nights because we spent so much time on foolish things. And when you did, we were so tired we just couldn't do anything with our evenings. You just didn't have any social life at all.

Q. What were you saying about human relations being tight?

Well, the supervisor was hard for everybody to get along with, and that made tension between the doctors and nurses. You got so you felt that. You felt exhausted all the time and it was the tension more than the work. We weren't nearly so busy then as we are now. She gave us wonderful training, I don't mean to criticize her. I'm grateful to her for that, but I must admit it is better around here now. You can really be yourself, even around the doctors. You can act natural, I mean. We still have to be polite, you understand, and wait on them and all that, but you can at least express your point of view. It isn't just we who are changing either. Things are changing all over the country. Now we have an aide to help us and our own maid and six graduates besides. You might say we have less work to do and more people besides. But the big thing is the lack of tension....

Strict obedience may have been easy for girls raised during Victorian times. They had been trained in parent-centered homes and had been

expected to show extreme deference to all older persons. It may have been relatively easy for them also to behave humbly toward the doctor. They stood when he entered the room and allowed him to precede them through doorways. In modern America, women are not accustomed to the role of subservience and the constant reminder of their inferior status in these symbolic acts was a source of humiliation to them.

In speaking of their experiences during their training years, they would sometimes become bitter:

You wouldn't dare to speak to the doctors. If you knew the chief surgeon was on the floor, you would hide. Everybody would hide. Here if the chief surgeon is on the floor you go up and make conversation. It's just altogether different. I don't know, I appreciated my training. It was a good school to learn in, but you never felt like an individual for one minute. There was always someone knocking you down. It sure wasn't any place to work in. All but a few of the girls in my class got out immediately upon graduation.

These quotations, it might be mentioned, are from nurses interviewed in different hospitals and trained in different schools. One Director of Nurses who is now struggling valiantly to build another kind of school said of her own training:

The first month I cried all the time. . . . Finally the Superintendent of Nurses sent for me and I was terrified. She didn't ask me to sit down or anything but just said sternly, "Miss Jones, I hear you are crying all the time. What is this, don't you like it here?" I was so scared I just replied, "Oh, yes." Then she said, "Well, this crying nonsense will have to stop." That was all she said, I was dismissed. . . . It was a hard three years. Never once in the whole time did I express an opinion on anything. None of us did, we just did exactly what we were told and never asked questions.

It is important to realize that some people adjust more readily than others to this kind of climate. Not all were rebels, but many were and they got out of the hospital as quickly as they could. There were many places for the young graduates to go. During the past twenty years the demand was increased for nurses in such fields as schools, industry, airlines, public health, and doctors' offices. Within the hospital the need for nurses was constantly growing greater, especially after the introduction of insurance plans which increased hospital usage, and technological changes in medical care which made it more urgent

than ever that the sick be hospitalized. When World War II came, and the armed services began recruiting nurses, the hospitals awoke to find themselves stranded. There just weren't enough nurses to go around.

Those hospitals of which we have most knowledge seem to have followed approximately the same pattern. Things appear to have jogged along in the old manner with people doing the best they could within a gradually worsening situation until the day came when the person who symbolized the old order, a director of nurses or administrator or board president, left the hospital either through death or retirement. Then the new order began to come into being, not with one grand splash but usually by inches.

So far as authority patterns are concerned, the change was slow indeed. The new authority would issue directives and would sometimes struggle valiantly to inaugurate reforms yet no changes occurred. One does not undo the work of generations in a week. One sympathetic observer commented:

It wasn't only this hospital, believe me. I saw the same thing happen in my hospital too [meaning where she trained]. Those older nurses were trained by a holy terror. When she walked into the dining room, everyone would stop talking and a distinct chill would come over the room. . . . Yet it was hard for them to adjust to the new Director. They were so used to taking orders that they didn't know how to think for themselves. She did everything to encourage them to make decisions at lower levels, to handle problems for themselves, but it was no go. They had been trained for years to take absolutely every detail up with the school office and they refused to have it different. I know in this hospital even after five years, they are still calling on the office to check on every trivial detail. It must be maddening for the director.

Not only that, they had been conditioned even in their attitudes. She would hold meetings for them and try to get them to express their opinion and they would sit there hostile. They were inwardly rebellious to every administrative decision and yet she couldn't get them to speak up. Then they would go out of the meeting and gripe their heads off among themselves.

The psychologist might think, of course, how could it be otherwise? To those caught in the situation it was a disappointment, particularly when they had attacked their problems with enthusiasms and high ideals only to find themselves resented, their fine schemes for introducing democratic participation sabotaged by the very persons they wanted most to help. The following chapter on the head nurse may

help to explain the full circumstances. Head nurses had been trained all their professional lives to behave one way and now suddenly they were expected to turn around and do just the opposite. How could they accept democratic patterns when all they knew were authoritarian ones?

In some of the hospitals we studied, ten to fifteen years have passed since the initial changes occurred. One might expect that the painful stage would have passed and a new equilibrium be established, but this isn't entirely true. Many hospitals evidently still find themselves with a hodgepodge of people and policies, shadows of the past and portents of the future. The dominant note in the nursing administration today is not autocratic rule nor yet democratic order, but confusion.

Let us consider briefly some of the many problems which result. As older supervisors leave and younger ones are substituted, one finds different patterns of control in the various departments of the same hospital. A student nurse in her junior year of training remarked:

Gee, coming here from floor Z was like moving from night to day. It was awfully difficult for me upstairs. I just didn't feel useful. You were afraid to do anything without asking permission first, and yet you didn't want to do that all the time either, so most of the time you just stood around feeling foolish.

(*Note: On floor Z the head nurse told the interviewer how terribly "lazy" these modern girls were!*)

Now when I came on this floor, I knew I would like it. All the girls do because they have more freedom here. There isn't anybody checking up on you every minute of the day and they work their heads off too, everybody does. They love it up here. You know, graduates from this school are still criticized when they go to other hospitals. They say we don't show enough initiative. The fact is, we aren't allowed to, on most floors. We always have to ask first before we do anything. That is all right too, in a way, you don't feel so nervous...but it doesn't develop much self-reliance. On this floor they use more modern ideas and girls love it.

It is known that vacillation is the hardest kind of authority to accept, that children of extremely strict parents are probably much better off than those whose parents are indecisive or in conflict with each other. What the modern student nurse faces is a variety of forms of authority. What she learns about proper deportment on one floor, she must unlearn on the next in order to fit in appropriately.

As the student struggles to adjust, the administration may bend over backward to assist her with the result that the older nurse on the floor feels left out, a "has-been." As noted above, the older nurse may have had every impulse toward initiative relentlessly pounded out of her. She may expect and need to have someone come around regularly to check up on her and give her praise or blame. She is distressed when this doesn't happen. We heard many complaints about lack of direction:

This director never comes around. It seems to me she should, don't you think so yourself? We used to get a real lift out of those rounds. You try to do what is right but then you get busy and it is always possible that you slip over something and I'm always glad if the director comes around. Then she will see the thing and let you know about it and that keeps everybody on their toes. Now my director always came around. After she came through, you knew that everything was going to be just right and that everything was in its place. It was something to work for.

Notice that this nurse's sense of security was shaken because nobody told her that her work was well done. She felt a lack of recognition and lost her satisfaction in working. It is beside the purpose of this paper to discuss the merits of the making of formal rounds. The interesting thing to note here is the attitude which employees take even toward such seemingly neutral activities. In order to meet the emotional needs of a variety of nurses trained under different schools of thought, both the supervisor and the administrator must be unusually sensitive and flexible persons.

Another complicating feature is the extended division of labor. In order to cope with the shortage of trained nurses, many additional groups were brought in to take some of the load off the faithful few. One of the "new" groups were older women who had been trained years before, married, and left the hospital field. Devices such as appeals to patriotism brought them back to the fold. In the light of the facts mentioned above, one can readily see why this further complicated the human relations picture. In addition, these women were terribly out of date. They may never have seen a blood transfusion given nor taken a blood pressure. The older nurse was placed in the embarrassing position of having to ask the student how to go about certain treatments. Where a "refresher course" was not provided to bring her up to date, she was at a terrific disadvantage.

At the same time that the retired nurses were brought back into

service, auxiliary helpers were hired to do the less skilled work. Practical nurses with training varying from three months to two years could do almost any of the routine nursing tasks except administering medications. Aides could give bedside care to convalescents. More orderlies were hired to help transport patients and were used extensively in the men's wards for bedside duties. Sometimes the proliferation of duties which resulted among these groups worked smoothly, with each cluster of employees carrying out its assigned tasks. Sometimes it didn't work out so well. The head nurse or floor supervisor was the one who assigned the work and had the responsibility for coordinating all members of her team. In some cases she had no experience or training in the management of people. To our observation, where there was basic insecurity among the nurses due to too rapid a sequence of change, fear of their jobs, or lack of clear definition as to where each occupational group's work began and ended, bickering and jealousy arose. There had to be a gradual easing in of new ideas and new people.

Changes in the field of nursing education added to their complications. Girls recently graduated from hospital schools sometimes found it irksome to behold the advantages that undergraduates were receiving. Students were being encouraged to go home week ends, to maintain normal social activities outside the hospital. Disciplinary rules had been relaxed. When the graduate nurse considered the high price she paid, she may have felt a twinge of resentment to see other girls receiving their R.N. with so much less personal sacrifice.

In the past the student nurse was subject to the control of every other nurse on the floor. Today, with the extended division of labor and with the enormous strides in medical technology, the student is sometimes being taught to look only to the clinical instructor and head nurse for direction. We have seen cases where she was deliberately taught to turn a deaf ear to instructions from other nurses on the grounds that they were behind the times.

The presence of the clinical instructor is new to some institutions. The instructors are part of the school faculty, not under the jurisdiction of the head nurse in charge of the floor on which they actually work, and their task is to supervise students. To fill these new positions, as well as vacancies created when head nurses left, some hospital administrators turned to younger women with academic degrees. This was due in part to pressures on hospitals to raise their teaching standards and in part to the fact that the younger women fresh from colleges

had training in modern supervisory and administrative techniques which fitted them into the new scheme of things. It appeared to be easier to hire them than to attempt retraining of older staff members. This meant that nurses who once might confidently have expected upgrading on the basis of seniority now realized that doors were closing to them. They were "has-beens," perhaps at the age of forty, too old to feel comfortable in the schoolroom and yet much too young to think of retiring. It did not serve to lessen tensions between administrators and general duty nurses, nor yet between nurses of differing educational background, that these injustices existed.

The problems of maintaining suitable order within such an entangled human situation are perhaps evident. It would simplify things if the supervisors themselves felt reasonably confident of their own course of action. However, it is a rare person who feels she knows the precise combination of firmness and leniency which is most desirable in the various situations which arise. Where there are human lives at stake, nobody would suggest that complete freedom be granted those of doubtful competence in bedside care, yet the old pattern of rigid control has broken down and new ones are still in throes of being worked out.

It may sound as if the situation were quite hopeless, but of course this is not so. We have seen people at work within it who brought humor and spiritual grace to the task and managed to find real satisfaction in finding a way out of this maze, but it is not an easy job and not many people would be up to it.

It is inevitable that other hospital personnel would feel the result of some of these tensions. There probably isn't a hospital administrator or doctor alive who hasn't felt frustrated and embarrassed in his encounters with nurses. One student remarked:

It is hard to know how you are supposed to behave. Of course the supervisors always stand when the doctor comes into the room. That's the way they were taught to do and they sort of expect you to do the same. You know perfectly well that some of the doctors are embarrassed when you jump up, especially the younger ones. They say, "All right, all right, sit down!" You know they don't like it any better than you do, yet if you try sitting down, there's always going to be somebody who looks at you funny.

Some doctors were slower to accept the new patterns of relationships than others, and hospital administrators occasionally found themselves

caught in the crossfire between such doctors and the outraged nurses. For example, one man told us about the problem he was having with operating room personnel:

We have just lost two of our best surgical nurses. They told the director of nurses that maybe when she was in training the nurses would take a lot of guff from the doctors, but not them! You know, surgeons can be the worst prima donnas of all. I had to tell the chief of staff about it. That was him on the phone just now. I said to him, "Phil, you will have to hold those boys in check. We just can't afford to lose good nurses like that. You're going to have to tell them to lay off."

One of the most bitter criticisms heard from doctors, administrators, and older nurses concerning the younger ones was that they were lacking in ethical standards. No matter how fiercely nurse educators insisted that students were getting precisely the same training in professional ethics as their predecessors had, the criticisms continued. How much credence should be placed in them?

Perhaps two things have converged to change the viewpoint of the nurse toward her work. The first lies in the emphasis placed on its various aspects. A noted sociologist, Everett C. Hughes, commented that there are several models of what "the good nurse" should be. The first is that of the professional medical technician. The second is the model of physical and mental comforter. This last has much in common with the old concept of the nurse as an angel of mercy. It came into disrepute among nurses during the 1920's and 30's when wages were falling and the devoted nurse saw herself and her kind exploited on every hand. It was about this time that nurses began to restructure their idea of what the profession should be. They no longer were content to be seen as primarily the devoted assistants to male professionals. They wanted to be recognized as professionals in their own right. They began to emphasize higher education and technical competence. The nurse as comforter, the person who provided "tender loving care," continued to be seen as part of the ideal picture, but certainly this aspect was less emphasized. In fact, it sometimes seemed to us that it was the student nurse and the older graduate who worked to keep this part of the ideal alive, while between them came a generation of nurses who were somewhat shamefaced about tenderness as an element in good patient care. They weren't quite sure that it was "professional."

Another force which influenced standards of nursing care was the

rapid turnover of personnel. Sociological studies indicate that there are at least two sources of morality, so far as most of us are concerned. One is that within the individual and arises as the result of natural goodness plus training in the home, church, and school. The other source of morality lies in the group with whom the individual associates. It was our observation that where nurses had worked together for a long period of time, they came to feel that they "belonged" to that floor and had a vested interest in maintaining its reputation. Along with the individual's desire to live up to her own standards was a reluctance to let her team down. Where turnover was acute, on the other hand, this second impetus to moral conduct was missing. Each individual felt isolated and perhaps discouraged in her fight to maintain standards. A truly good person probably remains good in such a situation but a weak one will develop a "what's the use" or "who cares" attitude. It was on such floors as these that nurses told us shamefacedly, "I would hate to have my old teachers see me now."

According to the nurses we interviewed, the extremes of demoralization occurred in civilian hospitals shortly after the war during the readjustment period. As the nursing situation stabilized, it became increasingly easier to establish and maintain both a high level of nursing care and *esprit de corps*.

Conclusions

The nursing profession has been experiencing a series of internal tensions arising from a convergence of several sharp changes, notably those in patterns of authority, division of labor, educational requirements, and developments in medical technology. All of the hospitals observed or heard about appear to have been caught in this confusion of currents. Some of them were found to be meeting the situation effectively while others suffered more severe dislocation. With the passing of time the underlying tensions appear to have been eased but the task of administration remains a difficult one.

The anxiety within the nursing group influenced its ability to relate effectively to other occupational groups. Doctors and administrators, as well as other types of hospital personnel, complained that the nurses were unusually hard to live with. In some cases individuals were held to be recalcitrant but more often it was perceived that the real trouble lay at much deeper levels. There was evidence that authorities within the nursing profession understood the basic problems and were hard at work assisting individuals and groups to encompass the

many changes which were being thrust upon them. This chapter has perhaps not emphasized sufficiently the way that the professional organizations have united to meet the situation and to cope with it effectively. The challenge provoked a common will to master stubborn realities.

THE HEAD NURSE AND HER ROLE IN HOSPITAL ORGANIZATION

WE OBSERVED A HEAD nurse at work on a busy morning. She was trying to get caught up on her paper work but every two minutes she was interrupted. Incoming patients, anxious relatives, visiting doctors and student nurses kept requiring her attention, often several of them at once. At intervals between patiently coping with them, the head nurse returned to her paper work and as she did so, she hummed. It was the same melody repeated over and over, one line of something vaguely familiar to us, and finally we recognized what it was. It was from an old hymn, and it went, "...while the nearer waters roll, while the tempest still is nigh." We shall be considering the tempest-tossed head nurse in this chapter, to see what her job is composed of, why it is so hectic, and what is being done to make it less so.

The Traditional Pattern

It may help matters to consider how hospital organization has changed and the effects this has had on the head nurse. One small hospital we studied reflected a pattern which we suspect was a common one in years gone by. In this case the director of nurses had been until recently in full charge of a training school for student nurses. In addition she supervised the graduate staff, she trained the auxiliaries and directly supervised patient care. She was also responsible for supervising the housekeeping and dietary work. She tended the drug room, distributed linens and provided for their replenishment, and acted as hostess to the hospital's official guests. She told us that upon occasion

she hadn't hesitated a minute to tend the furnace too, when nobody else was available to do it.

All of the employees in this hospital were under the immediate control of the director of nurses. There were "head nurses" on each floor but they told us that the only distinction between themselves and other nurses was that they had particular responsibility for seeing that hospital records were kept up to date. They had little authority over the behavior of others except to schedule duties and report absences and unseemly behavior.

Any serious complaint a doctor might have concerning the way his patients were cared for, he typically carried at once to the director of nurses rather than to the head nurse, and it was the director who reprimanded the nurse. The administrator conferred with the director of nurses daily and channeled through her any recommendations he had with respect to employee behavior or policy. In other words, she stood between the employees and all other authorities and any problem of coordination and control of either people or materials went to her for solution.

In larger hospitals this simple a line of command may never have existed. Certainly in the ones we studied or heard about, the head nurses had long since been given control over their own floors. In some cases what this amounted to was a series of little autocrats rather than one major one. The authority system was remarkably similar to that detailed above. The head nurse held power over everything and everyone on her floor, being equally responsible for food service, nursing care, any laboratory work done, and housekeeping detail. She supervised all the personnel, kept them supplied with working materials, and saw that equipment was maintained in good order and replaced when necessary. The only appeal from her control was to the director of nurses, who typically backed her up without question, most particularly where student nurses were concerned. It was felt highly desirable that they learn absolute obedience to authority.

As hospitals grew busier and more complex, this system of control began to break down, as the previous chapter has noted. A review of the major factors involved will quickly reveal the impact this had on the role of the head nurse.

The Work of the Modern Head Nurse

First we might consider her supervisory duties. As late as 1932, 62 per cent of all American hospitals with schools for nurses reported

that they employed *no* graduate nurses whatever, at the general duty level.¹ A graduate might serve as head nurse but her entire staff was composed of students at various levels of training. They tended to the needs of patients under her direction, cared for equipment, did house-keeping chores, carried trays, and did any other work she cared to assign them. Their subordinate position as students insured their submission to her authority.

As times changed, the employment of graduate nurses increased, partly in response to medical technology which demanded highly skilled personnel, and partly because of the growing scarcity of students. It is generally agreed that graduate nurses are not so easily supervised as students. Moreover, where turnover among nurses was acute there were additional supervisory problems, for nurses trained in different hospitals may vary widely in their command of theory and technique. The head nurse sometimes felt it necessary to keep newly employed graduates under close scrutiny until she was assured of their competence. This can be hard for a proud young graduate to accept.²

The employment of clinical instructors to supervise the work of students, discussed in the previous chapter, relieved the head nurse of some of her teaching duties. She remained responsible for the integration of the students with the rest of her staff, however, and worked with the clinical instructor to see that they acquired the various kinds of experience necessary to their training.

In addition to graduates and student nurses there were new auxiliary workers to be supervised. The chapter on these employees may serve to indicate how serious a problem they sometimes presented.

Still another nursing group working on hospital floors were the private nurses. The private nurse is an anomaly within the hospital

¹ 1939 *Facts About Nursing*, published by the National League for Nursing Education, 1939.

² "When the Grading Committee asked 500 superintendents of nurses: 'If you had your choice, which would you rather have to take care of your patients—student nurses or graduate nurses?' 76 per cent replied emphatically that they would prefer student nurses. . . . Following are the chief reasons offered against the use of graduate nurses: difficulties of discipline; extravagance in the use of supplies, lack of familiarity with methods and routines of the particular hospital, the fact that they are 'here today and gone tomorrow,' that they resent criticism, and increase costs to the hospital."

Quoted to us by Miss Virginia Dunbar, Dean of the Cornell University-New York Hospital School for Nursing, from a pamphlet, "A Study on Use of the Graduate Nurse for Bedside Nursing in the Hospital," published by the National League of Nursing Education, 1933.

today. Formerly she did most of her work in patients' homes. Today she may be found increasingly within hospital walls, where she cares for the acutely ill who require individual attention, and for the wealthy who wish full-time nursing service. In the hospitals we studied, the private duty nurse was not on the hospital payroll. She was a freelance worker, responsible only to her patient, herself, and her professional organization. The head nurse was not officially her superior. She was responsible, however, for maintaining order on her floor and this included the smooth incorporation of sometimes many private duty nurses. She answered their questions, saw that they had access to necessary supplies and drugs, that they were relieved for meals, and adjusted any differences which might occur between them and other employees.

The work of the head nurse continued to include the coordination of people and materials, but it should be kept in mind that "materials" had changed drastically. Now there was an elaborate technology to nursing. The head nurse was the one who introduced each new medicine and machine to the others. If anything went out of order, she was the one to whom the others turned for help. Keeping her staff up to date in techniques and procedures was often one of her most troublesome tasks, particularly where turnover among nurses was acute.

In addition to nursing personnel, a wide variety of other employees were gradually added to hospital floors. In most hospitals food service came to be placed under a centralized dietary department. Tray service people sometimes took full charge of food distribution, including even the feeding of patients unable to feed themselves. Floor dietitians visited private patients daily to get their menu choices or to adjust special diets. Social service workers had been added to hospital staffs and would confer with patients on their nonmedical needs. Orthopedic floors often had a physiotherapist visiting them daily. Technicians from the laboratory were on and off the nursing floors, taking blood samples and other specimens and returning to post their findings on patients' charts. Even housekeeping chores were being looked after by a separate department in many hospitals, with maids reporting to their own supervisors.

The head nurse remained responsible for the well-being of all of the patients on her floor. If the work of a maid, a dietary employee, social worker, or technician ruffled the feelings of a patient or otherwise interfered with the smooth operation of her floor, the head nurse could complain to the department head involved, but that didn't necessarily clear up the difficulty at once. In the meantime she was faced with the

continuing need to coordinate the work of all these people over whom her authority was often, to say the least, ambiguous.

Let us turn our attention to the patient. In the past, the typical hospital patient was an object of at least semicharity and was in no position to rebuke his nurse or to resist her authority. Even the occasionally wealthy patient was more easily subdued by the nursing staff than today, for in the past he came to the hospital only when his case was desperate. When he recovered sufficiently to be a psychological threat to his nurse (insofar as he began to order her around) he went home to complete his cure. Today the average patient isn't as sick as former patients were, for he comes earlier and gets better faster. Moreover, he has hospitalization insurance and therefore a more independent spirit. He is much more likely to communicate with his nurse in a vigorous fashion. This doesn't necessarily mean that he complains, of course, it may be simply a joking relationship. The point is that the nurse must now adjust to him almost as much as he is required to adjust to her and to hospital rules. When he becomes difficult to handle, the general duty nurse calls upon the authority of the head nurse to bring about more cooperative relations. Once the hospital administrator or director of nurses visited every bedside daily and dealt with any problems that arose. Today they cannot do so, the patients are too numerous. Serious problems still go to the top but others are left to the head nurse for solution.

Even the relations of doctors to hospital floors have changed, and this also influences the work of the head nurse. We discussed in earlier chapters how some hospitals saw tension increased between the medical staff and the administration. When this happened, the director of nurses was almost inevitably pulled into the administrator's corner, for she was after all his employee. In one hospital the chief of the medical staff had this to say:

We think the technique in the nursery isn't what it should be, for one thing. They should be more careful about sterile techniques, but when we say anything about it they tell us it is none of our business. Now it is administrative business! I think it stands to reason that doctors are in a better position to see what the nurse does or doesn't do than the administrator is, if only for the simple reason that doctors are working up on the floors and he's working down here. When we talk to him about it, he says we are interfering with personnell I don't mean to complain about the nurses. The doctors and nurses get along all right around here most of the time, it is just that sometimes we think a nurse

isn't doing as good a job as she might be but we don't dare to criticize her. The administrator tells us it is none of our business.

At this particular hospital the turnover of nurses had become chronic. The administrator was struggling to relieve pressure on the nursing staff, and part of his task as he saw it was to teach the medical staff to bring their complaints to him. The doctors were reluctant to do this. They preferred to continue expressing their forthright opinion on the nursing floor where the immediate problem lay.

On the floors, it was the younger nurses who were both hardest to keep and most vigorous in rebuffing any perceived officiousness on the part of the medical staff. The head nurses for the most part were older women who had been trained in a day when the doctor's authority was unquestioned. It was to these older women that the doctors turned with their problems. In all of the hospitals we studied we heard tales about how this or that floor was the favorite of this or that doctor. Usually it was the familiar story of an older physician turning to a sympathetic woman close to his own age who could be expected to be tolerant of his foibles and strict toward her nursing staff. In other words, where interaction between the medical staff and administrative offices grew cooler and less frequent, it was usually increasing in volume between the doctor and the head nurses. They were the ones who struggled to smooth things over.

It is not surprising that in the face of these many pressures, some head nurses retreated. There are many ways in which one can run away from overwhelming problems. In some hospitals women were *raised to the position of authority over nursing floors* because they had worked there the longest and had proved to be excellent craftsmen. Sometimes they had had no experience whatsoever in organizing the work of others. Such a person, since her field of competence lay in the art of nursing rather than in supervision, tended to do what she was best at, which was to give direct bedside care. She put off the other parts of her job, resenting the time spent on paper work, supervision, and teaching. Sometimes a head nurse would have so much pride in her own command of nursing skills that she found great difficulty in accepting the less perfect work of subordinates. She would follow each student or auxiliary around, picking up where they left off and finishing the job for them. In her eyes they were individuals, and not very responsible ones, and she never saw them as a possible team. No effort

went into coordinating their activities and little in teaching. No time was spent in getting their point of view.

We do not mean to belittle the hard-working head nurse. In some instances she was respected and loved just because she was selfless in her giving and superb in providing bedside care to her patients. Her willingness to help with the work and the example she set of devoted service outweighed her obvious limitations. Nevertheless, the floors of such women suffered noticeably from lack of organizational skill. When the tempo of the floor did slacken a bit and the head nurse found herself with some extra time, she typically spent it on housecleaning chores such as tidying medicine chests rather than working on administrative matters which urgently needed her attention. It was her way of avoiding the areas of her work where she felt least adequate.

Another type of retreat was that taken by the head nurse who centered all of her attention on paper work. Sometimes this was an older woman who looked upon her promotion to this post as a graduation from hard labor, a kind of semiretirement from the strains of bedside care. In other cases the head nurse seemed genuinely convinced that it was wrong for a supervisor to help with routine tasks. She may have been overly anxious about this because of previous experience under someone who did too much of the work and failed to develop initiative among her subordinates.

Paper work, of course, tremendously increased throughout the hospital during the past two decades. It was one way to keep control over a rapidly expanding organization. For the most part the nurses, like doctors, despised paper work. Even where it was seen as an integral part of research, the actual keeping of records was regarded as a stepsister to the curative arts. It was only the occasional head nurse who was paper-oriented. Sometimes this seemed to be rooted in a desire to please superiors. Everything had to look just right on the records. The aim in life of such a head nurse was to keep things running smoothly. Any deviation from the routine was an occasion for anxiety and resentment on her part, and criticism from higher authority was taken as proof that her staff had somehow let her down.

It was our feeling in some situations that these work-minded and desk-minded supervisors suffered mainly from lack of proper training for their work. If they had been given confidence in their own abilities through adequate preparation, they might have relaxed and done a better job of supervision. During the war and immediate post-

war period, many new graduates were tossed directly into the job of leadership without training, or even experience under competent direction. Others had taken brief courses in ward management where they received instruction in modern administrative techniques but they lacked a practical approach to their problems. It was this latter type of person who sometimes had the notion that a good supervisor disdained to use her own hands at nursing tasks.

The theory that a supervisor should stick to supervising may make more sense in business than in hospitals. Where techniques change rapidly, a nurse who doesn't keep in practice may become out of date in a short time. As a result her staff loses confidence in her as a craftsman.

A third kind of retreat from the full responsibilities of leadership was made by the head nurse who tended to bypass administrative detail and even sometimes good patient care, in favor of improving staff relationships. She looked to her own employees for support and approval, placing too much emphasis on the maintenance of their good will. We found in talking with such people that they had often been victims of the work-minded or paper-minded head nurses and were so discouraged by it that when it came their turn to lead, they went in the opposite direction. They went out of their way to express appreciation and encouragement to their workers and hesitated to reprimand them for anything, no matter how deserved.

In our experience this type of head nurse was often popular at first, particularly with the thoroughly competent members of her staff who were grateful for their new freedom from control. Students, however, did not prosper under this kind of supervision, nor did older nurses who had newly returned to their profession. Such people felt timid about displaying their inadequacy. When an unfamiliar or difficult task came along, they tended to sidestep it, leaving it for someone else to do. This placed a heavy burden upon the competent and willing few. When the lazy or weak slough off their duties, the conscientious and strong have to carry all the load. In time the faithful ones grew restive under this and the appearance of good relationships would begin to be disturbed by undercurrents of dissatisfaction. We were repeatedly struck by comments among both students and graduates that they preferred head nurses "who give a lot but who demand a lot too." They respected those who could command effort on the part of the entire work group.

Some head nurses who grew up under the old order were able to

blend together the best of the old and the new ways of doing things. They managed to maintain orderly floors and at the same time to enlist the support of their staffs. Lucky is the young nurse who had opportunity to serve under such leadership. Personal interviews with successful head nurses brought out the interesting fact that such individuals were modeling themselves after someone under whom they had worked previously. Usually this was a head nurse for whom they felt deep respect. Occasionally the reverse was the case, and the young nurse would tell us that she had at least learned what *not* to do. Poor head nurses could give us no clear picture of either very good or very bad supervision. They had only had experience with the mediocre. Is it any wonder that they were doing mediocre work themselves?

In one hospital the students and graduate nurses could be counted on to mention Floor X whenever we ask them to cite which floors were considered best run. Floor X was for surgical patients. The head nurse was one of the older women who had managed to keep at least abreast of the times if not one step ahead. She was the first in this hospital to inaugurate the "team system."

On her floor the team system worked this way: There were three corridors. To each one she assigned a group of student nurses, auxiliaries and one graduate nurse who was to act as team captain. The captain planned the work of her group. Each nurse gave complete care to the patients assigned to her that day. The "team" aspect consisted in the pooling of resources and knowledge. The group discussed each case briefly at the start of the day, considering the total needs of the patient. They called upon one another for assistance where the work required more than one pair of hands. The captain supervised the work, saw that each student shared in all kinds of experience necessary to her training, and assumed full responsibility for the patients' welfare. She sometimes took upon herself the care of the sickest patients, taking the newest student along with her to demonstrate the correct procedures. In the quieter periods of the day such as visiting hours, she again called her group together for informal discussion of the patients and their care. In the intimacy of this small work group even the most timid student felt free to participate.

The head nurse on this floor was known to be strict. She demanded and got excellent workmanship but what was more, she got enthusiasm. On Saturday morning when no operations were scheduled, it was her habit to get all of the floor staff together to discuss the interesting cases in rich detail. It was then that ideas would pour forth. Students and

graduates would discuss the patients who weren't making the progress hoped for, and what alternative types of care might be used to bring about improvement. The head nurse told us:

I know that people *do* have ideas and if you can pool them, you can pick out the best ones. That way everybody has more interest in the work anyway. The senior students especially have good ideas. They will come and say, "Don't you think we could try this or that?" I always say, "Well, all right, let's try it and see how it works." That gives them more of a feeling of self-confidence.

Discussing the team system, she commented:

Well, it means that there is always somebody there to help you if you have to pull up a mattress or turn a patient. It also helps the patients because there is always an older nurse on hand to see that things are done right. It gives the graduates a sense of responsibility they wouldn't get otherwise. What I do, I hold meetings of the team captains once a month to discuss floor policy, and then hold a meeting for the entire staff and throw the discussion open to the whole group. If anybody comes up with a new idea, the group likes to give it a try and then they report back on how it worked out. I make rounds of all the patients twice a day and that gives me a chance to see that everything is as it should be.

This head nurse, with her floor well organized and under control, had time to get acquainted with her patients, knew all their histories, followed their progress with active interest, and was in a position to communicate to the doctors in detail just where a patient's needs were not being completely met. Her students and graduates helped to keep her informed.

Elsewhere the team system is being used to bring together an even wider variety of workers. In some hospitals, for example, the social service worker, dietitian, and physiotherapist may join in the group discussion of plans for the day and the review of patient's care. This is a feasible technique when each floor has such employees regularly assigned to it. When they, like laboratory technicians, travel all over the hospital in the course of a day's work, it is harder to incorporate them closely into the plans of any one floor. It then rests with the head nurse to relate her staff effectively to the work of other departments, so that the timing of duties coincides appropriately and the patients receive the best care with a minimum of delay.

It has been said in an earlier chapter that the personality of a hos-

pital administrator sometimes permeates through an entire institution, and almost anyone who has worked in hospitals can bear witness to this. It is probably equally true that next to the administrator, the head nurse determines the climate of a nursing floor. She is the one who decides whether the work shall be patient-centered, doctor-centered, or nurse-centered. More than anyone else she sets the pace of the work day, determines where the emphasis shall fall and which tasks can be hurried through. The average employee soon learns her preferences. It is within the limits of the floor that many people develop their sense of belonging. Floor staffs sometimes become tightly knit groups, loyal to each other and fierce in their defense of the floor reputation. They have been known to rise magnificently to emergency situations, supported more by their belief in each other than through any motivation which top management could possibly supply. It is the head nurse, more than anyone else, who can influence this *esprit de corps*.

In order to bring about successful integration of her team, the head nurse herself needs the support of her superiors. If she is discouraged and confused, she will lack the motivation sufficient to do as good a job as she is capable of.

The Head Nurse in Relation to Her Superiors

The final chapter of this book will deal with interdepartmental relations. This one will therefore confine itself to the place of the head nurse within the nursing department.

One reason why head nurses had come to have so much control over their individual floors was that as hospitals mushroomed in size, it became virtually impossible for a director of nurses to supervise the total institution. She was kept busy with recruiting personnel, directing the training of students, and determining over-all policy. It was her task not only to maintain her department but to relate it effectively to other institutions such as the state department of education, professional nursing associations, and community agencies such as women's auxiliaries. Like the administrator, she became steadily busier with public relations matters.

As the pressures accumulated, it became customary for directors of nurses to appoint administrative assistants. Two areas of responsibility were usually marked off from each other. The first was nursing education. The second was termed "nursing service" and included the

employment, administration, and supervision of all those directly involved in nursing care. The nursing service administrators we met were usually kept more than busy with problems of employment and administration. Hence, the supervision of nursing care came in time to be delegated to still another level of persons, sometimes called administrative supervisors.

The administrative supervisor thus came between the head nurse and the assistant director in charge of nursing service. The supervisor usually was responsible for several head nurses and floors, or some special department or division of work such as the sterile supply division. In one hospital the obstetric supervisor had under her charge the head nurses from all delivery rooms, labor rooms, nurseries and postnatal floors. Her work included the staffing of these rooms and floors, the engineering of the flow of supplies, and the coordinating and improvement of nursing procedures.

The latter task was of considerable importance. In hospitals where head nurses had become accustomed to autonomy, the nursing procedures and techniques used on various floors had grown out of line with one another so that it had become difficult to shift personnel around from one floor to the next to meet changing needs. For maximum efficiency, more uniformity had to be brought about and this was a task which supervisors sometimes found difficult to accomplish.

In one hospital the position of administrative supervisor was relatively new and the women in these jobs were still groping their way along. It wasn't clear to them or to others whether they were line persons with full authority to order changes, or staff persons whose task it was to advise and help line personnel such as the head nurses. One of these supervisors said to us:

It's hard to put into words. You just don't quite belong anywhere and you don't feel secure. It isn't that they want to be mean to you downstairs, but you feel as if nobody quite sees your point of view, and sometimes you aren't too sure yourself where you fit in. . . . The head nurses here aren't being paid what the supervisors are. If they were, I'd never be a supervisor. Being a head nurse is the most satisfying thing in the world. You have everything under your control and if there is anything you don't like, you can change it.

The supervisors at this hospital never knew clearly how demanding they should be. The head nurses didn't know how to behave in the situation either. They were accustomed to making their own decisions

and now somebody had been added to the scene. One head nurse commented:

One thing bothers me. We have too many people telling us what to do, too many people in authority. We have a director and now we have a supervisor too.... They come on the floor and see situations which don't seem right to them. Now often I will have noticed these things myself but will just be too busy at the time to take care of them. I'll put them aside to be taken care of at my first opportunity. Usually when the supervisor brings it up, I'm so busy at the time that all it does is interrupt my train of thought. It really can be quite bothersome. I think if these people would only leave me alone, I'd do a smoother job.... As it is, it sets up a feeling of antagonism, almost. That is my biggest problem.

Q. Is the supervisor supposed to do that? Is that part of her job to go around and see what is going on?

Well, that's something I wonder about too. Sometimes I just wonder what capacity is being filled by her. As it is, she pops up and I don't know what authority she is going on. Now this other person above me I can accept, but with this one, I just don't know. If we were told how we could cooperate with her, it would be easier for everybody. I know it bothers the head nurses on the other floors, too.

One can see that much of this mutual embarrassment must have been due to a transitional period. It was a matter of people accommodating themselves to new ideas and situations, and that included persons at all levels of the organization, for those at the very top also had to learn to delegate authority and responsibility in clear and mutually acceptable ways.

In another hospital we came upon a supervisor whose work was more narrow in scope and more clearly defined. This was an older nurse, a woman in her late sixties, who had been a very successful head nurse. Her present duties were to work with newly appointed head nurses, to help them adjust to their new responsibilities and to organize the work of their floors.

We watched her at work on one floor where things had become chaotic. Her procedure was to stand by the young and struggling head nurse, encouraging her to think through the various aspects of the work, deciding for herself which things were to be done first, which second. The new head nurse soon caught the spirit of the work and began to move ahead rapidly, scheduling the tasks of the day so that

at least the imperative ones were finished and then as many of the others as possible. The head nurse told us:

When I first came to this floor the work seemed unsurmountable. Now it is better organized and everyone on the staff seems more enthusiastic. I think they just feel more up to the demands made of them, and I do too. When you have more work than you can accomplish, you get so downhearted that it doesn't seem worth while starting. Now the efficiency has improved, more can be done because there is order. It used to be that we didn't get the morning work done before the doctors came in to make rounds [about 11 A.M.]. We just about died when Miss Callahan insisted that we could be through the routine by 10:30, but now everybody takes real pride in having everything in order by that time.

As the new head nurse got her department under control, this supervisor went ahead and worked side by side with the regular staff, helping with the ordinary chores. She prided herself on her technical skills and set an example to the others not only in efficiency but in the grace and skill of bedside nursing. Her effect on morale was tremendous. The weakness and danger of her role, to our observation, was that she was so excellent in her human relations and had such a compelling character that within a brief while the patients and staff were turning to her rather than to the young and struggling head nurse. She became the apex of all activities and until the administration removed her, the younger woman was left feeling considerably frustrated despite the fact that her work was under control.

In another case an experienced nurse was put over several obstetric floors. She did classroom teaching, supervised students on the obstetric floors, and handled the administration of personnel and equipment. The head nurses who served under her were considerably younger and looked to her for guidance. Top management of the hospital, through long familiarity with this supervisor, had acquired respect for her judgment and regularly gave her views careful consideration when issues arose. In addition to the support she received from her superiors in the administration, this supervisor was upheld by the medical staff, in particular by the chief of obstetrical services. A busy man, he conferred with her on policy and left the daily management of the department in her competent hands. It was his custom to hold a monthly dinner to which were invited the supervisor, the head nurses, the social worker in charge of obstetric cases, the internes and residents

currently assigned to the department, and such practicing physicians as were interested in coming (and several came regularly). After an excellent dinner there was an informal discussion session. Progress was reported, gripes aired, and plans laid. The head nurses here fitted into a well-knit team, and the department ran with notable smoothness.

This picture of a successful department might be analyzed into its component parts. A good working relationship had been worked out between the supervisors and the head nurses, each understanding the role of the other. She was in a position to relate them effectively to the rest of the hospital, to top management in particular. And she had the support and help of the medical staff. Perhaps all of these elements were important in bringing about the effectiveness of her administration.

Communication Upward

Having a sympathetic director of nurses or an administrative supervisor who can represent you effectively to higher administration is one thing. Representing yourself is something else again. Some directors of nursing found that it wasn't sufficient to set up intelligent administrative procedures. They also had to enlist the participation and interest of the head nurses in improving the nursing department as a whole. This was particularly the case where people and procedures had fallen behind the times, or where tensions had been developed between sections of the nursing department, for example between the teaching faculty and nursing floor employees. We shall discuss the development of improved communication among departments in our final chapter. It is sufficient to say here that in many hospitals, the nursing department was the first to feel the need for bringing people together on a face-to-face basis to talk things over and to pool ideas about improving patient care.

One hospital began to do this on a high level, with administrative supervisors sitting with the director of nurses to discuss the division of labor among themselves. The discussions then turned to employment policies, the orientation of newly employed nurses, revision of nursing procedures, and public relations. Before long the discussion technique had proved successful enough that the supervisors began to hold similar meetings for head nurses and their assistants. Then the total nursing group asked for meetings and were organized into discussion panels.

Another hospital nursing department had a carefully worked out committee system. In this case it was not a spontaneous development but one which had been carefully worked out from above. Virtually every head nurse was on at least one committee and some of them were on several. We heard grumblings about committee work taking too much time from the work of the floor. In general, however, the meetings were appreciated. The topics discussed concerned such things as the introduction of new techniques or efficiency devices. It was common for volunteers to try out new ideas and then report back to the others the results of their experience. In this way changes were initiated slowly with the experimentally minded setting the pace for others to follow more leisurely. A major consequence of the meetings was the greater familiarity which people gained with each other and with the problems of the hospital as a whole.

One head nurse said:

I never have trouble in taking up problems with the nursing organization. We have faculty meetings once a month and everybody is there from the different departments and you can bring up your problems and can comment and give your opinion on other people's too, and there is a good spirit there. You are always free to express your opinion. We have committees too, you know. I'm the head of a couple of committees. They are very important. It isn't always easy to fit in committee meetings on a busy day, but I do think they are worth while.

Summary

We have been regarding the head nurse chiefly from the place she occupies in the total organization, showing how her job changed as the hospital itself changed. Once, in the typical small institution, her role was a modest one indeed. With a director of nurses in complete command not only of the nursing department but of other service departments as well, the head nurse was concerned only with the direct supervision of patient care. Even disciplinary problems occurring on her floor were passed along to the director. The head nurse's subordinates were student nurses and maintenance people such as maids.

In the course of time, hospitals developed rapidly and the centralization of authority broke down. The head nurse was responsible for coordinating not only students but graduates, private duty nurses, new groups of nursing auxiliaries, and many other levels of employees. In addition she had more urgent problems to meet in her relations

with the medical staff and with patients as well as more paper work to do in order to relate her floor effectively to higher authorities.

We know of no other role in our society which quite compares in complexity with that of the head nurse of a hospital floor. Supervisors in industry do share something of her predicament when it comes to keeping abreast of a rapidly changing technology. Hotel managers must cope with customers on a twenty-four-hours-a-day basis. University professors make distinctions between their professional and their administrative duties. The captain of a ship at sea, like the head nurse, behaves differently in crisis situations from noncrisis ones. He also must be able to cope with emergencies, keeping alive his skills as a craftsman as well as an organizer of work. But he, at least, is in unquestioned authority over all those aboard his vessel and he knows quite precisely to whom he in turn is responsible. The head nurse shares the problems of all those mentioned above, plus the fact that she must answer always to at least two sets of superiors, the medical staff and the hospital administrative hierarchy, and she must coordinate a bevy of workers over whom she often has only nominal control.

This difficult and exacting role is still being thought through. A good bit of interest is being directed to it, on the part of national hospital and professional nursing organizations. Meanwhile these women remain the chief link between the staff of the average nursing floor and the rest of the hospital.

CHAPTER 9

SOCIAL SERVICE WORKERS

THE MEDIEVAL INSTITUTION from which the modern hospital grew attempted to care for a very wide range of human ailments. With the rise of scientific medicine based on laboratory research, in the latter part of the nineteenth and early part of the present century, the concern of the hospital came for a time to be limited largely to physical illness. More recently, however, there is a growing realization that problems of physical illness are often inextricably tangled with social and psychological difficulties, and that the best of medical and surgical care alone cannot always be depended on to restore the patient to health. The advance of psychosomatic medicine offers convincing evidence that symptoms cannot be effectively treated in a vacuum.¹

The Job of Social Service

One result of this recognition has been the rise of medical and psychiatric social service. Social work in the hospital setting is a recent development, found as a rule only in larger institutions and by no means in all of them. Although the social worker's hospital role is based partly on the expanding idea of therapy sketched above, it is also related to the increased specialization of medicine which tends to bar the physician from his traditional function of counselor and general family adviser. The social worker's job is hard to describe

¹ For an interesting discussion of social and psychological aspects of illness, see Leo Simmons and Harold G. Wolff, *Social Science in Medicine*. New York: Russell Sage Foundation, 1954.

briefly, for she is involved in a range of problems as rich and varied as the lives of the patients. One might say that her central task is to assist in relating the patient's environment and personality to his medical treatment in such a way that the treatment may have maximum effect. In some important respects, she tries to supplement the communication between doctor and patient, interpreting the details of the patient's situation to the specialist and helping the patient understand fully what his illness and its treatment mean.

The social worker provides emotional support and counseling, as well as factual information and material services, for her client. She must be very skilled in interpersonal relations and very adept in utilizing the resources of the hospital, welfare agencies, and other institutions. Although some of her work is quite concrete, dealing with diet, clothing, housing, and financial aid, much of it is intangible, falling under the heading of morale. The trained social worker acts to increase the spiritual resiliency and self-understanding of the patient. Her hospital role may be compared with those of the nurse and dietitian, two other professionals who contribute to medical treatment.

Like the nurse and the dietitian she is a member of a professional association determined to maintain and extend her position of prestige and her function. But the nurse participates much more closely in medical care and inherits a well-established relation with doctors, a philosophy of service and recognition as a key member of the hospital team. And though the nurse belongs to a professional group which extends beyond hospital walls, her daily work doesn't bring her into contact with the world outside. The role of the dietitian is more obvious than that of the social worker. Most people, lay and professional, can understand that proper nourishment is critical to medical treatment. The emotional nourishment offered by the trained social worker is a less tangible contribution, although its importance is increasingly recognized. Also, the technical skills of dietitians are concerned chiefly with things. Their relations with patients are fewer and less intense. The dietitian can concentrate on calories and avoid the drain of psychic energy which marks interaction with a dependent client. On the whole, nurses and dietitians probably are in a more stable position in the hospital organization than social workers. Their tasks are more easily recognized and evaluated. On the other hand, neither group has the freedom of action and the flexibility in defining the limits of the job which is possessed by an alert social service department.

The Social Worker as a Professional

The functions of social work have been carried on for centuries by laymen, but social service is a young profession. It has only recently become recognized as a technical field with a body of theory and practice, and appropriate methods of training to qualify it as a profession. It is even now in a stage of transition from common-sense helpfulness to a sophisticated discipline. Social workers are typically a young, eager group anxious to attain recognition as an established profession.

As a young profession, social service shares many characteristics with other groups in the hospital which are also striving for recognition and an established position in medical care. Laboratory workers, dietitians, and others join the social worker in a desire to emulate the secure status and high prestige of the doctor. There are at least two central concerns of the blossoming profession which social service exhibits in its hospital activity: a concentrated effort to raise and define the levels of training and competence expected of full-fledged members of the profession; and a persistent attempt to define the duties of the social worker in relation to other staff personnel and to clients. The first of these concerns is shown in the increasingly strict standards of the field, the demand for master's degrees and rich practical experience. These are sources of pride to the social service department, a tangible measure of its discipline and hard-won status as a specialty. The second major concern, that of staking out the distinctive hospital function of social service, appears not only in the intensive self-examination of motives and goals but in the strains and rewards of interaction with the doctor, nurse, or administrator. Because this department is a relative newcomer, its duties are often ambiguous or ill-defined and each member is to some extent responsible for phrasing her own role.

It is natural for a professional group, striving for recognition, to expand its duties toward the range of activities it feels appropriate to full professional standing. This expansion, sometimes coupled with the aggressive drive of a department growing in stature, may foreshadow conflict with other groups over jurisdiction, rights, and duties. Social workers may even feel that this conflict is a necessary part of the professional task in a hospital situation. Thus, the director of one social service department was critical of workers in other hospitals who got along too smoothly and easily with the rest of the hospital staff. She asked, "But are they really doing social work?"—as if suspecting that their good relations with doctors and administrators

rested on passivity and a willingness to perform something less than the full professional task.

A highly developed professional sense also contributes to an atmosphere of solidarity and congeniality which seems to distinguish the typically small social service department. There is a tendency to form a tightly knit group. Such a group is likely to exhibit high morale, a spirited, zestful attitude toward its work. This intimacy of understanding is found very often among professional colleagues, but is perhaps most intense in the small group whose standing is not yet wholly secure. While a "we-feeling" has many positive implications for the satisfaction of group members and the quality of their work, the heightened spirit of belongingness may have potentially negative features. Perhaps the most prominent of these is the pattern of sticking together against outsiders, which is admirable for departmental purposes but may, if carried too far, generate clannish or snobbish elements. The aura of exclusiveness or very special competence may provoke misunderstanding on the part of other hospital employees. For instance, in one hospital a pharmacist lightly described the social service department as "the mind workers," for he thought they seemed to be an exotic group far removed from practical matters.

The relationship of the department to the hospital work flow contributes to the tendency toward exclusiveness. Because its duties are highly specialized and because it deals with only a fraction of the patient census, it is relatively independent of the hospital system and is not a part of the normal flow of hospital work. It is *in* but not completely a part of the system. As a bridge between the medical world and the larger world outside, it suffers the fate of all bridges, suspension without totally belonging on either bank.

But the fact that it is a small, ardently professional group also helps it in the performance of its work. The common background of the workers facilitates communication on patients' problems and cooperation within the staff. And the tradition of competence and technical knowledge gives a feeling of real pride in the work. Like so many hospital duties, social work gives the satisfaction of altruistic endeavor, and like a few of them (e.g., medical care and nursing) it has the additional lure of intrinsic *technical* fascination. The social worker appears to feel an interest in the solution of social and psychological problems similar to that of the physician in physical problems.

Major Aspects of Hospital Social Work

. In a memorandum to the house staff, a director of social service recently stated the function of her department in this way:

The hospital maintains a staff of trained medical and psychiatric social workers to assist patients with social and emotional problems related to illness. Broadly speaking, the function of the department is to help the patient find the most practical solution to any problem which may interfere with his making the best use of medical facilities.

This statement sets forth three major elements of hospital social work which have important implications for human relations both within the department and toward the hospital as a whole. The first element mentioned, the existence of a trained staff, has been discussed in considering the social worker as a professional. Special competence and a desire for relative independence from administrative control are characteristic of the profession.

Second, the department's role is "to help the patient find the most practical solution to any problem which may interfere in his making the best use of medical facilities." That is, the workers are facilitating agents whose job is to assist in medical care. They are in a consulting, subordinate position to the doctor, not independent practitioners. Their situation parallels that of the nurse who is eternally outranked by the physician even if her capacity in a specific instance is superior to his. As one social worker expressed it, the key fact in defining her hospital role is that "social work is not the primary discipline within the hospital structure and must gear itself to the medical profession."² This feature of social work, with special reference to the psychiatric setting, is also remarked by an outside observer who emphasizes that in an organization the worker is always dominated by a higher status professional.³

The third critical point is that social service is "to assist patients with social and emotional problems related to illness." In other words, the social worker has a therapeutic relationship with individual patients. Her work is more than a simple humanitarian task of helpfulness. It is a system of knowledge and techniques designed to enable

² Laura Jane Henrich, "The Role of the Medical Social Worker Within the Eye Services of a General Hospital." M. A. Thesis, School of Social Work, University of Buffalo, 1951.

³ Otto Pollak, "The Culture of Psychiatric Social Work," *Journal of Psychiatric Social Work*, June 1952.

the patient to work through his emotional and social problems. The job is not necessarily fulfilled when the gross material needs of the client have been satisfied, since adequate diet and housing, for instance, can be best utilized only if the individual's emotional stability is also adequate. It may be essential to interview other family members, to survey the patient's environment, perhaps even to carry him in supportive therapy as a client of the psychiatric clinic. The social worker then does more than a "practical" job of bailing unfortunates out of temporary jams. She brings specialized gifts and training to bear on a complex problem of rebuilding individual capacities.

Relations with the Administrative and Medical Staff

Until recently hospital social workers have been regarded as a luxury, and one still find traces of this attitude. Not every large hospital, however excellent, has a social service department. It is an unusually advanced administrator who regards it as a critical and basic part of the medical system. The primary function of the hospital is medical care, and although there is increasing recognition that the patient must be treated as a whole person, psychiatric and general environmental factors are rarely given emphasis at all comparable to that placed on regular medical and surgical treatment. Patients are sent to social service if there is some special reason, as they are sent to x-ray, but it is not surprising that physicians recognize the need for x-rays more quickly and surely than the need for social work.

People do not come to a general hospital explicitly for social counseling. Once they are there it may be discovered that their medical progress hinges on a complex of factors including emotional rehabilitation, economic relief, or expert advice on family problems. But this is extra, a way-station on the road to medical recovery. The social worker does not expect to recruit her own patients in the hospital, nor would it be considered desirable for her to do so. Most of them are referrals from medical, surgical, and clerical staffs. Since the doctor is the key decision-maker and initiates action for a variety of workers, professional and nonprofessional, the usefulness of any special department depends primarily on the extent to which the medical staff recognizes its role in the healing process. Doctors' recognition of social service varies widely. Some use it extensively and some not at all. To most, the social worker is probably a valuable consultant but one who is rarely the first to be called on and is seldom seen as a key figure in the doctor's view of the medical team. The continuing education of

doctors and nurses about what the social worker's function is and could be is an extra task for the social service department. In a teaching hospital this is especially important, since the house staff of today will be the attending staff a few years hence. One social worker described the way a resident physician came to lean more and more on her as he observed the help she could actually give his patients. At length she said with some pride, "A recent referral was made with this statement by the ophthalmologist to the patient: 'This is Miss H., the social worker. She can explain anything you want to know about your operation and can help you with other things, too. She's a good person for you to know.'" This relationship of the doctor to the social worker is an achievement and was only attained after months of experience. He had learned what she was like and what her special talents were, especially in explaining the patient's condition to him, and by referring the case he gave the social worker recognition. The worker was able to begin her task under favorable conditions which included a positive recommendation from the doctor. This situation contrasts sharply with one of no referral, or a grudging, hesitant one.

Another problem in referrals is appropriate timing. In many cases social service is consulted too late to be fully useful. The director of one department told of an instance in which an elderly patient was not brought to the social worker's attention until the day of his discharge. It was then learned that he had no home to return to after leaving the hospital. Such time lags are especially harmful in psychiatric difficulties where a few weeks' delay may mean a steady worsening of the patient's condition. Social workers also often protest the use of psychiatry as a "grab bag" category, to which patients are referred only when the physician can think of no medical solution.

A major portion of the social worker's facilitating role is what is known as "interpretation." The social worker explains the practical meaning of the doctor's diagnosis to the patient and also outlines the patient's environmental situation to the doctor. Many patients find it difficult to understand medical jargon and the doctor, especially in a clinic, often hasn't time to explain his judgment in detail. The same time pressure may prevent the doctor from getting a full background of the patient's problems. Some fragment of the life history which the physician didn't have time to uncover may contribute to medical care when it is later supplied by the social worker.

In community agencies social work is the cardinal discipline. But in a hospital it is greatly dependent on the tolerance and support of

the "host agency," and the workers are of course subject to the administrative controls which govern other employees. What kind of a host is the hospital? One we studied provided the social worker with a favorable environment but still withheld full recognition as a vital cog in the organization. Members of the department spoke jokingly of their status as an "orphan." This good-humored self depreciation cannot conceal the very real hurt which social service workers feel, from evidences of lack of acceptance. For example, when much remodeling was taking place in the hospital, social service was assigned to a fairly cramped area in the "old building." They carried on a war of attrition in their fight for newer desks, better lighting, and more space, and made sarcastic comparison between the furniture in their department and the rich appointments of the neighboring electroencephalograph room. Several of them half seriously said to the observer, "Please put in your report a request to Dr. Adams for new desks for us." The resentment was not based entirely on concern about prestige. Their therapeutic efforts were severely handicapped because they had to interview several clients at a time in crowded offices.

Relations with Patients

Social workers speak of "carrying" a case, and handling a case "load." These expressions are not mere figures of speech, for the psychological cost of shouldering another's burdens is substantial. The social worker involves herself more or less fully in an ongoing relationship with a dependent client, which may include most of the features of psychotherapy: the achievement of initial rapport, coaxing forth of a range of problems, the illumination to the patient of his own true condition, and the conclusion of the process when the patient attains a degree of maturity. And over all, or perhaps under all, the social worker must provide a continuing emotional support to the weak and confused. Of course, not every case demands such thoroughgoing treatment. Most individuals require only a segment which may be as "slight" as the provision for a proper diet. But all clients need generalized support and this is perhaps the most demanding on the worker.

To be effective she must be a person of above average maturity; even though she is unusually stable, the relationship to a client imposes severe strain. Special sensitivity such as the social worker needs is often accompanied by increased irritability, so the social worker may have a rather "low boiling point." Workers may be at times impatient and guardedly hostile in their relationships with one another, although the

general spirit of cooperation and mutual respect is much stronger than the minor tensions. Nevertheless, dealing with complicated interpersonal relations for long hours is a severe strain and results in a backlog of frustration which must be released in some way.⁴

The nurse also undergoes the pressures of long-continuing efforts to help a faltering individual to mature. But she can release much of the resulting tension in physical activity. She can actually do something in a concrete and satisfying way. The effects of her work are there for her to see and so she can obtain a sense of accomplishment far more readily. Bathing and comforting a patient furthermore tends to establish a relationship more quickly than does the quiet counseling of a social worker.

The social worker spends much of her time listening to clients and is schooled not to display disapproval or fight back if they become aggressive. A sophisticated observer of social workers remarked on the disparity between the free and yielding behavior which is desired in the therapeutic relation and the rather formal organization of the staff work itself.⁵ While allowing the client great freedom, the social worker often hems herself in with a strict professional procedure including voluminous reports to the chief and a variety of superior-subordinate relations between senior and junior workers. Workers are very careful to point out who supervises whom in any work situation.

Human beings seem to need a certain amount of structure and definition in their daily tasks, and perhaps the very lack of a stable pattern in the counseling situation leads to a strong desire for pattern in other aspects of the work. And the fact that the counselor has to give so much support to her clients may make her especially in need of support from the case work supervisor.

Perhaps the most important thing accomplished by social service is a long look at the whole patient. No one else in the hospital has the time and few have the skill to see the patient as a complicated human being in a total environment outside as well as inside the institution. The social worker puts the pieces back together on the social level just as the diagnostician pieces together scraps of information from laboratories, histories, and so forth. Her understanding of the whole

⁴ The surgeon exhibits some of the same strains, and his explosive outbursts are a traditional although increasingly less well-accepted part of operating room society. But he has two distinct advantages: his status is secure and high, and the reasons for strain are visible in the surgical situation in a way in which the stresses of social work can never become explicit.

⁵ Pollak, Otto, *op. cit.*

person may have implications for medical treatment, as when a social worker opposed the doctor's recommendation that a certain elderly man be moved to the county home. This would have been medically suitable since where he was living he had to climb stairs which added to the stress on a tired heart. But the social worker knew that this old gentleman was at home in his neighborhood where he could chat with friends and roam his familiar haunts. She felt that he was being kept alive in large part by a warm human environment. So the man stayed where he was, and the doctor's medical diagnosis was discounted in favor of morale factors. This story also illustrates that the social worker, if she is forthright enough, can have an important influence on patient care even though her policy conflicts with the recommendation of the physician.

Because the relationship between the patient's physical and social condition affects his recovery, there is an area of overlap and possible conflict between the special interests of the physician and the social worker. When differences of opinion occur, she is at a disadvantage because she lacks his status and explicit authority. The problem is especially acute in psychiatric social work, for here the division of function is even less clearly marked than in the medical sphere. At times the unclear separation of roles makes the worker protest that she is being asked to go beyond her professional competence, as when a worker complained of being forced to decide whether or not a new admission showed suicidal tendencies. At other times, in keeping with the striving professional spirit, social workers maintain that they are not allowed enough influence in medical and psychiatric decision making.

Conclusion

The professional medical or psychiatric social worker is performing a relatively new and little understood task. Her work in the general hospital is an auxiliary discipline, which has to fit into a going concern, while medicine is the central profession.

As a small, highly expert group, the social service department usually exhibits a congenial atmosphere marked by strong feelings of solidarity. The warmth of internal relationships, however, sometimes contrasts with a more anxious, strained relation to the rest of the hospital. This possible tension stems in large part from the novelty of the worker's role, and from the fact that her duties are loosely defined and incompletely accepted by other hospital groups. It should be empha-

sized that the burden of proof is on the social worker, who must structure her role so that her work may be integrated with the efforts of physicians, nurses, and others. If others in the system need to learn her worth and accept her competence, so too the social worker needs to become a part of the system by adjusting social service goals to the hospital pattern. Medical social work cannot flourish as a wholly separate specialty but as a highly developed set of skills adapted to the medical context.

Social service is a demanding profession, but the worker is to some extent compensated for psychological strain by the rewards of a comparatively free and expanding occupational role.

CHAPTER 10

CLERICAL EMPLOYEES IN THE HOSPITAL

General Features of Clerical Work and Workers

THE WHITE-COLLAR WORKER is one of the few hospital employees whose job is often directly comparable with one outside the institution. Most clerical skills are readily transferable from the hospital to business or industry, and it is only rarely that an individual in these fields comes to the hospital with special training for specific hospital tasks. She is thus set apart from the professional workers whose training is highly specific. She is also set apart from them in that she deals with symbols, words and figures, while most of the staff members are concerned with physical events. Nevertheless, white-collar employees are fully involved in the work of the hospital because of their vital role in keeping essential records and maintaining the network of communications. They are important in facilitating the flow of information between the hospital and the public and within the hospital itself.

It is difficult to define the limits of the clerical staff, for it includes a variety of persons in many departments and levels of the organization. However, the major jobs to be considered in this chapter are of two types: those involved in recording and systematizing the mass of detailed information connected with hospital work, embracing secretaries, clerks, typists, accountants, business managers, and medical records specialists; and those concerned primarily with communications, especially telephone operators and receptionists.

Clerical workers often feel a strong identification with the aims of their organization and a loyalty to the administration. Perhaps because they deal with *official documents*, and represent the institution in its dealings with the public, they are particularly apt to think of the hospital as an enduring fact, a self-maintaining organization. Some older employees, much like the devoted nurses who traditionally lived only for the hospital, have literally given themselves to the goal of keeping the institution afloat. A veteran business office supervisor showed these attitudes when he said:

All my life I have gotten to work early and it's too much of a habit to break. I'm tough on myself and I'm tough on my girls. People have different ideas. Some of the supervisors think you should just sit around and watch other people work, but I could never do that myself. I have always worked hard and I have never asked my girls to do anything I wouldn't do myself. I guess there's only two kinds of people in the world, those who like to work and those who don't. In the past, we did just about everything, everybody helped out wherever the need was greatest. We were working 8:30 to 6:30 almost every day and lots of times late into the night during the war. I guess we were putting in fourteen or fifteen hours a day then. All we had time for was sleeping and working.

Obviously, such an intense allegiance to the hospital, while frequently encountered, cannot be expected of most employees. Newer workers may regard their jobs quite casually, and a noncommittal attitude is relatively general in young office personnel who are searching for an occupational niche and may think of the institution as a way-station.

Since the clerical job itself can rarely be described as distinctively medical, we must look for elements in the hospital environment which distinguish it from the usual office position. What are the satisfactions and dissatisfactions of nonmedical work in a medical atmosphere? Perhaps the outstanding positive feature is an opportunity to identify with the members of the healing professions, to feel oneself a part of the curative enterprise. This element is very important, despite its vagueness. Not only does the hospital's mission provide intrinsic satisfactions, but the prestige of professionals—doctors and nurses—tends to spread to the less highly skilled employee. One finds clerks wearing the symbolic white jacket with its flavor of science and authority. Then too, people who work in hospitals are often credited with special health knowledge

by their friends and relatives on the outside. They are thought to be privy to the mysteries of disease and cure, and in fact sometimes serve as informal consultants on medical matters. Actually, nonmedical hospital workers often do pick up a certain understanding and vocabulary which may lift their advice above the level of gossip or misinformation to the point where it is truly helpful to outsiders.

Although the generally accepted value of the healing arts contributes to the clerical employee's sense of usefulness, the hospital setting is not designed to enhance his prestige relative to the rest of the staff. White-collar personnel are not as favored as they are in business and industry because of the hospital's reversal of the normal relation between status and type of job activity. The top medical workers are manual workers, with the doctor as model. They manipulate instruments and people, while their executive counterparts in other occupations deal with abstractions from experience in the form of ideas and numbers. When the person who works with his hands, the production worker, is at the peak of the organization, then the clerk cannot benefit in prestige by his freedom from manual labor.

The hospital atmosphere, it may be seen, carries potential rewards and penalties. Nowhere does this emerge more clearly than in the effect of patient care on nonmedical employees. The presence of illness, and of the agents of cure, is at once repellent and fascinating. Hospital workers are usually intensely interested in the cases which surround them, the excitement of disease and accident. They often express great curiosity about the details of illness and treatment, for these are things which impinge on the psychological system and pattern of values of every individual. One cannot easily be neutral about living and dying, or about the possibility of learning more about others' lives. With the fascination goes fear, a keen realization of the truth that all men are mortal. Clerical workers often speak of revulsion before the more threatening aspects of hospital life, the sight and sound of suffering, the drastic ministrations of surgery. An exaggerated fear of certain diseases may be observed, and even a kind of occupational hypochondriasis, or "medical students' disease," in which the knowledge of symptoms convinces the imaginative person that he suffers from them. Some clerical personnel state that while they enjoy serving the hospital, they could not stay on the job if it were too closely connected with direct patient care. A young messenger girl recalled her experiences as an elevator operator:

I ran the elevator for a while, but it got too tough for me. The internes used to get on carrying packages, and kid me about what was inside. Once one of them asked me to hold a box for him, and when he took it back he told me it contained an amputated leg. I finally had to tell Mr. Roberts [the personnel manager] that he would have to transfer me or I would quit.

The surgical department often has trouble holding qualified secretaries. Secretaries assigned to the surgical floor have spoken of nightmares, and of their fear of entering an operating room with a message for the surgeon. Yet, of course, many white-collar employees adjust extremely well to medical and surgical situations. It can be very comforting to know that excellent doctors and fine facilities are at hand if one should become ill. The hospital, in a fundamental way, protects and nurtures its employees as well as its patients.

The security, psychological and social, of hospital work is frequently mentioned as a source of deep satisfaction. In common with nurses and other staff members, the office worker enjoys the hospital's traditional concern for the personal well-being of its employees. A strong paternal element has long been a feature of hospital employment, although increasing organizational size, higher wages, and more formal personnel policies are combining to reduce its scope. Individuals like to tell of how their co-workers are taken care of by the institution, treated when they fall sick and shifted to easier duties if their energy falters. One middle-aged man employed in the business office said:

When I was hospitalized last summer, the hospital wrote off \$700 of my bill as an employee's service and the Blue Cross took care of the rest. My doctor's bill was also free. There is one of the advantages of working in the hospital.

Also the people here were interested in how I was getting along. Dr. Sampson [the administrator] and Mr. Corrigan [the personnel manager] visited me very often and the nurses on the floor made my wife comfortable. When I was really sick, they brought her a reclining chair so she could relax while she stayed with me late at night. Anyone in this hospital, even the orderlies, could get just as good care as I got.

Another reason employees give for enjoying hospital work is that it is not so standardized or routine as in a factory. They prize the variety and find the jobs interesting because of the changing duties. They also feel that the hospital is not an exceptionally demanding employer, allowing some freedom of action. A secretary commented:

I think the reason many people stay for many years in fairly low paid jobs is the atmosphere of freedom in the hospital. We are not chained to our desks and we do not have to account to anyone during our working day. I can slip out for coffee when I please. I can do my work at my own speed. This feeling is more important than a few extra dollars in the pay check.

There are, then, many reasons for preferring hospital work. Especially for the younger worker, these reasons must be compelling if she is to stay with the institution, since hospitals compare poorly with outside employers on several points. Gross economic questions, such as wages, hours, holidays, etc., usually find the hospital at a disadvantage. The hope of financial betterment is surely a potent consideration to people who leave the institution. Underlying the other economic difficulties is the paramount fact that upward movement in the organization is not a real possibility for most of the clerical staff. The hospital system is a classic example of "blocked mobility," with the professional staff monopolizing positions of high pay and responsibility. Advancement is sealed off for the majority of employees by virtue of their lack of training in medical skills, a lack which cannot be repaired by on-the-job schooling. As clerical work grows more specialized to fit the medical world, and moves toward professional stature, this situation may change. But today there are few rungs in the clerical ladder; its top is usually a supervisory position over a small clerical group.

Relations to the Public

The business office, the reception desk, and the telephone switchboard are critical points of contact between clerical personnel and the public. These contacts deepen the identification of the worker with the hospital. She represents the hospital to the public and what she does has a significant effect on public relations and patient attitudes. At the same time, these relations involve a certain amount of strain. In Chapter XIV the admissions office is described as a focus of many pressures from patients, doctors, floor nurses, and the administration. People in the business office, the reception desk and the telephone switchboard also have to deal with these pressures. A business office is subject to a widespread internal hospital conflict in a particularly acute form: that between humanitarian ideals of service and the business ethics of financial solvency. Although the immense increase in prepayment insurance has eased the situation for both patients and business office employees,

these workers are still caught between the public's reluctance to pay for an unpleasant and unanticipated occurrence and the feeling of trustees that balanced budgets are an unquestionable virtue. They are not only caught between these two pressures but are in conflict within themselves as well. On the one hand they feel a real concern for the financial stability of the hospital and on the other hand a genuine obligation toward unfortunate patients, and often some feeling of guilt at the necessity of demanding payment. One of the workers said:

I've just been crying with a patient again. It's your job and you have to go through with it, but it makes me feel ashamed sometimes. I feel like a villain in a play.

But the head of an office in a small hospital, with long commercial experience outside the medical field, proudly exhibited her books showing the month's collections running a thousand dollars ahead of the month's expenses. She said: "I try to run this office like a business."

The conflict is eased when the hospital has a standard procedure for bill collection which is firmly followed except when unavoidable exceptions must be made. In larger hospitals a credit manager may remove some of the pressure from harassed cashiers and clerks. He may also be in a position to deal more flexibly with patients, having a higher status and more discretionary authority than the clerk. He is especially trained to help people meet their obligations and to handle the emotional accompaniments of financial strain.

A similar problem besets the receptionists. One receptionist summed up her situation in this manner:

✓ There are two philosophies in this hospital; one says you should follow the rules and the other says rules are made to be broken.

Q. Which do you follow?

I see myself as a buffer between the two. Most of the time I try to follow the rules, but sometimes it seems to me that for the patients' sake they should be broken. At first I was afraid to say or do anything but now I just keep quiet and let them in. I tell them, "If anybody tries to stop you just tell them I gave you permission, and they should contact me." Then I hold my breath and wait for trouble.

Q. How does your system work?

I'm really surprised how well it really does work. I know often the floor supervisor doesn't like it, but so far they have let me get away with it.

The receptionist, as gatekeeper for the flow of visitors into the hospital, meets the public directly every day. Many of the people she deals with are especially upset and impatient. The hospital is set up to care for patients but is sometimes very inadequately prepared to cope with their families. Illness draws families closer together and the patient often needs psychological support from those close to him. Although a recognition of psychological and social needs, in addition to physical ones, is growing more common in medicine, most hospitals find that the pressure of work tends to make relatives a nuisance to staff members. Visitors, many administrators feel, must be controlled in numbers and distribution, both for the patient's sake and the convenience of employees on patient floors. Since floor personnel, especially the head nurse, are already very busy, the responsibility for regulating visitors falls to the receptionist. She must combine firmness with flexibility, must compromise the staff's demand for freedom from family interference with the visitors' desire for unlimited access. Her resourcefulness is strained by many conflicting demands, as seen, for example, in the custom of "mass visiting" by certain ethnic groups and the frequent rhetorical question from impatient relatives, "What if it were *your* mother (son, father, daughter)?"

Internal Communication

Hospital organization is so complex, the integration of many semi-independent groups so necessary, and the nature and volume of work so variable, that continuous, effective communication is essential. The white-collar workers prepare and transmit a very large part of the written messages which keep the hospital going. But written communication is too slow for many situations, so the telephone is of tremendous importance. The telephone operator at her switchboard is at the literal core of hospital communication. She realizes that a certain proportion of the calls she handles are extremely urgent and grave; the vital character of her job is self-evident. The tension which she cannot help feeling is complemented by a sense of importance and a realization that she is at the strategic center of hospital affairs. She usually knows or infers the most significant happenings, and this awareness adds interest and excitement. Since the work demands constant alertness and staffing around the clock, fatigue and overtime hours may generate occasional irritability.

Perhaps the most difficult problem that the operator faces is the failure of doctors to respond to repeated calls and paging. If the doctor

persistently refuses to cooperate she may have to bring the authority of a superior to bear on him. A telephone operator in a large teaching hospital described such an incident:

I was eating at night in the dining room. A doctor who was sitting across the room was being paged. He got angry at this, rose and shut off the paging system. I got very uncomfortable because I realized how dangerous this is. I have gone frantic trying to reach someone. Then one of the other doctors put the system back on again. When the girl began paging this doctor again, he got up and turned it off again. I was so upset that I reported it to Mr. Morgan, the administrator, the next morning. I didn't want to tell him the doctor's name because it had happened before and it isn't always the same one, but he insisted, so I told him.

The interviewer asked:

What happens when one of the doctors is so recalcitrant that your patience wears out?

She laughed and said:

I just have to lay them out in clover. If they do not respond I call the head resident. He is the type who cracks a whip over people and co-operates with me very well. All I have to do is tell Dr. Jackson [the head resident] that I am having trouble with somebody, and he tells me he will take care of it and then it clears up.

One administrator, well aware of problems like this, deliberately oriented his incoming internes, residents, and attending physicians to the significance of the operator's role. He tried to convince them that the telephone operator is potentially their best friend or most dangerous enemy. The same administrator, realizing that his telephone operators were isolated from the rest of the hospital because their switchboard was located in an out-of-the-way place, made a practice of visiting their room and inquiring about their problems. In this way he was able to foster a sense of participation in the general life of the hospital among the operators, a sense they might have lacked despite the importance of the switchboard as a communication center.

The relation between operators and doctors is very congenial, on the whole, and affords certain opportunities for joking and talking in an informal, relaxed way. Telephone operators perform many services for the doctor, such as holding messages or shielding him from unnecessary outside calls, and these services are usually appreciated.

Relations with Other Hospital Groups

In general we found the relations between the clerical staff and other hospital workers to be harmonious. This is perhaps partly because clerical workers are threaded through the institution in such a way it is difficult to identify them as a separate group. Nearly every section of the hospital has its clerical staff. In part, too, the harmony may rest on the fact that clerical workers do not compete with other professional or nonprofessional duties that are more directly concerned with medical care or dependent on manual skills. Nevertheless there is some tension in coordinating their work with the professional workers because of the difference in the emphasis on goals. The clerical staff is naturally concerned with systematic, detailed record-keeping and accounting. Doctors and nurses on the other hand tend to feel that records are of very secondary importance compared with the concrete and pressing job of caring for patients. They recognize that records are necessary to efficient hospital operation, but they are apt to grow impatient when they have to take time out from their more important work to help keep them up to date. They recognize them as a means to an end, but are apt to suspect that clerical workers make them an end in themselves. Furthermore, much of the professionals' work is unpredictable and they meet crises by improvisation. They are apt to consider the clerical workers' insistence on meticulously following procedures as petty. This conflict seems to be found almost universally in the doctors' delinquency in keeping up the medical records.

Professionalization

As in many other parts of the hospital, there seems to be some tendency toward professionalization among white-collar workers. The growing complexity of hospital insurance and welfare assistance, and the drive toward more careful and complete accounting procedures, require more highly skilled personnel, and the introduction of well-trained people with degrees in accounting or business administration. The medical records librarians have their national organization which is working to establish standards and qualifications. Schools are introducing training programs specifically planned for medical secretaries. As developments such as these increase, they will influence the white-collar worker to think of herself not so much as the clerical worker who has a job in the hospital, but as a hospital employee doing clerical work.

Summary

As hospitals grow in complexity and an increasing variety of skills must be utilized, competent clerical work becomes increasingly important. In the past, the clerical skills called for have been interchangeable with those in the commercial world. There are some indications that clerical work in hospitals is beginning to be a specialty. There are signs of incipient professionalization. Though clerical workers serve the therapeutic purpose of the hospital only indirectly, they are in the mainstream of hospital activities since they are a vital part of its communications both with the public and between staff members. While the material rewards are generally lower than for similar work elsewhere, many hospital employees find the work particularly satisfying because they can identify with its goals and prestige, because their work is more varied and more self-directed than elsewhere, and because it affords both psychological and vocational security.

THE NEW NURSING AUXILIARIES

LONG BEFORE HOSPITALS or professional nurses were dreamed of, there were women who did amateur nursing as a means of livelihood. In our own times, who does not remember the neighbor who could be called upon to give help when a new baby was due to arrive, or when the whole family came down with the measles at once? This is as much a part of American neighborhood life as it is in any other part of the world, but we have been slower than other peoples, perhaps, to give official recognition to such work and to make it subject to licensure. In many communities, until just recently, the so-called practical nurse was often seen as one who would cook meals for the family as well as care for the mother and new baby. She was called upon to look after the chronically ill and the convalescent, while the registered nurse with hospital training was given the work of tending the acutely ill person. It was only during World War II that hospitals across the nation began to employ the amateur nurse in large numbers. Then suddenly, when the shortage of registered nurses grew most acute, several new levels of auxiliary nursing groups were added to hospital staffs, often in rapid succession. These groups were given various titles. Sometimes they were called ward helpers, sometimes aides, or nurse assistants, or practical nurses. In some instances the names were interchangeable from one hospital to the next, but gradually they came to mean different things. The ward helper usually was the least skilled of the auxiliaries. She did such work as filling water pitchers and running errands. The aides and nurse assistants gave simple bedside care

such as making beds and feeding patients too ill to feed themselves. The practical nurses achieved the highest status of the auxiliaries. In most states they are now required to complete formal courses of training and to pass competitive examinations. Their national organization is working to consolidate their gains and to win them the permanent place in the hospital for which their training prepares them.

Characteristics of the Auxiliary Workers

All new occupational groups apparently go through a period of probation during which time they must strive for recognition and acceptance. The nursing auxiliaries were not always greeted with kindness. In some hospitals they were given uniforms to wear which resembled those of the maids and were treated like housekeeping employees. They had to fight for the right to wear white uniforms (symbol of the medical worker in our society), for really adequate technical training, and for broader opportunity to use their skills. As in the case of other new occupations, there was at first a wide variety of people employed and part of the difficulty lay in this diversity. On the one hand were the diligent, ambitious ones, often mature women who took on additional responsibilities eagerly as a way to prove their worthiness. At the other extreme were youngsters who drifted into hospital employment and took temporary jobs while they made up their minds what they wanted to do with their lives. In time, the more responsible women tended to move into the better jobs, but some admixture was still present in the hospitals we studied.

An example of the dedicated type of person was Helen, a woman whose family had been "healers" for generations, and who quite evidently shared their sense of calling. Helen's parents, grandparents, and an uncle had worked in backwoods areas among the lumberjacks. They earned their living as lumbermen or as midwives and on the side did what they could to relieve suffering among people who had no other medical service available to them. Helen told us that her grandfather had owned and passed on to his son an ancient textbook on surgery which they studied carefully and referred to before any piece of work was attempted. It is difficult to realize that such things are still within the life experience of Americans, but here was this woman working as a nurse's aide in one of our modern hospitals. Her ambition was to achieve a license as a practical nurse.

Another aide claimed never to have held any job for more than six months. She appeared to be extremely intelligent but had had no edu-

cation to speak of and, starting during the depression, had roamed the country exploring all kinds of occupations. Margaret commented animatedly on the medical cases in the ward where she worked, describing symptoms in a way which would have done credit to an interne. Her head nurse told us that the only trouble with Margaret was, she attempted to do things beyond her range of competence and had to be watched closely.

On the same ward with Margaret was the other type of aide, a young woman who said frankly that she took hospital work because nothing else happened to be available to her at the time. Where Margaret worked unstintingly and obviously enjoyed her contact with patients, Mary used most of her interview time complaining about them. She said that some were "real stinkers."

They wait until you are busy and then they all start yelling at once. It got me rattled at first, but after a few days I found out which ones you have to be firm with and which ones you don't. Now I can say to them, "I'll be with you in a minute" and the patients will simmer down and wait. I found if you are firm with them, they will adjust to it and not pester you so much. Of course, some of them are pretty nice too. Some will even help out and pass bedpans to other patients and make their own beds. They really go out of their way to make your load easier and you appreciate that very much. I'm certainly learning a lot about human nature.

Mary claimed that she learned her techniques for subduing patients from watching the graduate nurses.

Selection and Training

These examples of an over-eager and a perhaps under-eager aide may serve to indicate how necessary skillful selection and supervision can be, in the case of auxiliary workers. Naturally persons with serious intent were preferred, and most hospitals gave priority to local women with experience in home nursing. All of the hospitals we studied, however, had at least a quota of younger girls in the ranks below the practical nurse level. It was this younger group which seemed to benefit most from careful instruction and supervision.

A portion of these girls came from underprivileged communities, often from depressed areas of the nation. They were new not only to their jobs but to city life and sometimes to the acceptance of responsibility. They brought attitudes and opinions to their work which other

employees found, shall we say, exotic. Not only did these girls need to learn a new way of life, but the hospital in its turn needed to adjust its ideas to cope with them. For example, one supervisor had this to say:

They are really very good workers; I haven't any real complaints to make at all. Of course, problems do arise but this is because it is a different class of people than I'm accustomed to dealing with, and they have different work habits. For instance, they don't have the habit of working steadily in one place for any length of time. I almost never get anybody who can give me a reference of a place where they worked for more than three months. Another thing, they don't give you notice when they are leaving. If you are lucky, they'll come up and turn in their uniforms. . . . This is awfully hard for the head nurses around here to get onto. They can't understand why I can't tell them a month ahead of time that their aide is going to leave and have a new one trained to take her place. I can't convince them that with this type of worker you can't expect this. It is unreasonable to ask, it just isn't in their tradition. This is just a different kind of employee.

This supervisor had been working with these girls for more than a year and was doing an excellent job of encouraging stability among them, according to hospital authorities. Her insights into their work habits fit very neatly into what Dr. Allison Davis¹ had to say about the short-range goals of underprivileged workers. When people have led a hand-to-mouth existence as many of these girls had, their "psychological time" comes to be measured in days and weeks, whereas a more secure person plans in terms of years. Perspectives can be changed, of course, but such fundamental adjustments in outlook take time.

In another hospital a supervisor with similar problems was working to increase the feeling of stability and security in her workers in this way:

One thing I'm doing is to make up job analyses and descriptions for all the auxiliaries. I find that people feel more secure if they know just what they have to do. Do you find that? They want to have a basis for praise or criticism. If they know what is required of them, then they know whether they are fulfilling the job or not. The type of people we are getting today can only do routine things. You can't be too vague about it or they will be frustrated. They must have something definite.

¹ Allison Davis, "The Motivation of the Underprivileged Worker," Chapter V in *Industry and Society*, edited by William F. Whyte. New York: McGraw-Hill, 1946.

This supervisor had the wisdom to consult both head nurses and auxiliaries and to get their participation in drawing up her job descriptions. For the most part, people were pleased with the finished product and we found her work being referred to in many instances. On the other hand, insofar as the aides on different floors were found to be doing different work, it pointed up another problem which she had recognized but had not yet been able to solve, the acute need of a uniform training program. For example, one of her nurses' aides pulled a job description sheet out of a drawer and pointed out the items listed on it.

Do you know what a sitz-bath is? I don't. I've been an aide here for nine months and still have never given one and what is more I wouldn't know how to start. If anybody ever ordered me to give one, I'd die. The same thing with enemas—I could probably figure it out if I had to, but nobody ever showed me. A lot of things a person can figure out from their own common sense, but some things really require training. Another thing which worries me is sitting beside a patient who is just coming out of an anesthesia. How do I know when a person is just unconscious and when they are going into something deeper? All you can do is sit beside them and feel scared to death, because you don't know how to help them and if anything went wrong, you wouldn't even know it.

At this particular hospital, as in several of the others, the training of a new nurses' aide was theoretically in the hands of the head nurse on that floor. What really happened was that these busy women were turning the task over to experienced aides and asking them to please "show the new girl the ropes." Sometimes this worked out satisfactorily, more often it didn't. The following tale illustrates the kind of situation we found to be common. This particular aide was respected by the nurses on her floor but was experiencing difficulty in getting along with the other aides.

I have the duty of training the others and this isn't fair. I had three girls train under me and all of them were very nice girls, too, but still they seemed to resent the fact that I had to tell them what to do. If I said we will have to do this or that today, they figured that I was giving them orders. I think they should be trained by some authority, don't you? Then when they come on this floor, all I would have to do would be to tell them where things were kept. You see, they want to feel your equal and yet they aren't up to it yet. How can they be equal when they don't know the work?

In all the hospitals studied we found that it was well recognized that aides required uniform training given by a person of superior status and ability. The problem lay in how to get this accomplished. With aides coming and going it was a discouraging business to contemplate making the initial investment. A few hospitals managed to train all of their aides at one time. In other instances it was felt more desirable to select a few from among the many. None of "our" hospitals made the mistake which we heard about elsewhere, of selecting the aides who needed training the most. While this appears logical, it obviously has the severe handicap of making training seem to be a punishment, something to be ashamed of. The hospitals we studied chose the opposite course and trained the cream of the crop. These women were selected by their work supervisors as the "most deserving," i.e. of relatively stable disposition and good work habits. The head of the training program told us:

When they finish their training, we call them "nurse assistants" and now all the other aides are coming to me and asking why they can't be nurse assistants, too. I have to tell them that they select themselves. When their work is of a sufficiently high caliber, they will also be in line for training. See, I deliberately picked the girls who were most conscientious and faithful and now they are an example to the others. The others feel that there is some reason for working hard now. Before this they figured what was the use.

We came upon these "nurse assistants" in their pretty new uniforms throughout the hospital. They were going about their business in an efficient manner and bore themselves with poise and a new self-confidence. *From all accounts they were more than earning their small raise in pay.*

Rivalries

Any situation where changes are occurring can be expected to show a certain amount of strain as people struggle to accommodate themselves to the new order of things. This was true here as it was elsewhere in the hospital. Let us consider first the tensions among these workers themselves.

As the newly promoted girls returned to their floors and began to work among the unpromoted, there were indications of tension. In one case the new nurse assistant was expected to do some of her old chores as well as the new ones and the unpromoted aides insisted that

she "share and share alike" until all the common tasks were finished. Only then would they permit her to begin her additional duties. They insinuated that she "thought she was something," and exerted subtle pressure on her to prove that she still was of a democratic spirit. We found this youngster scurrying about trying to do the work of two persons, and learned that she had hit upon the strategy of coming in to work an hour earlier in order to get things under control. She was not reporting this additional hour and her superior apparently had no idea what was going on. This may sound extreme but it was not new to our experience. Workers must live with each other as well as with their superiors and most of them are deeply concerned that they be accepted by their fellows.

Such problems were less acute on floors where the work of the new nurse assistants was sharply delineated from that of the unpromoted aides. A typical example is the reaction of an aide who related in detail just what the new duties of the promoted girls were and when she was asked whether she would like to do such work herself she replied,

Oh yes, yes very much. In fact, I'm looking forward to it. The supervisor says she thinks she can get me into the next class in September.

The fact that this aide was accepting the situation didn't necessarily mean that it was tensionless, of course, but merely that it was easier to handle tensions gracefully when everyone knew what the distinctions were and how they, in turn, could climb the ladder of success.

This same aide was meeting competition from another source too. She remarked in her interview:

We get along with the maids just fine. In fact, they help us a lot of the time. One of them keeps doing aide's work. I told her the other day, "Look, if those patients ask you to do something for them, just tell them that they should ring the bell. After all, there is no reason why you should do your work and ours too, it isn't fair to you."

Is it being cynical to suppose that she saw the maid as coveting her job? Occasionally a maid did ask for transfer to the nurses' aide department, and this raised certain problems too. The housekeeping supervisors would accuse the nursing department of raiding them of their most promising people, just as they were getting experienced and really helpful. What must be faced in such instances, of course, is the price paid by the hospital when transfers and promotions take place

and conversely what price is paid when they are *not* provided, the feelings of frustration and hostility which may then arise.

The problems faced in industry are similar, of course, but in a hospital there are more than the usual factors to be considered. It is especially imperative in the field of health that individuals do not overreach their respective areas of competence. A glass of water given to a patient whose fluid intake is being restricted could conceivably be a serious interruption of therapy. Therefore careful training and jurisdictional control must be exercised at all levels.

The problems among aides and assistants were duplicated at the next higher level. The practical nurse stands between the nurse assistant and the graduate nurse and in many hospitals feels pressure from both sides. The people below her may resent her superiority and complain that she "thinks she is really something now that she wears that white uniform" while the graduate may protest that the practical nurse is presumptuous, an ignorant person trying to pass herself off as well trained. We came upon many examples of aides, practical nurses, and graduates engaged in jurisdictional disputes. Usually it was a case of the underdog trying to extend her range of activities into the next higher bracket of responsibility and privilege, only to be beaten back with the argument that she lacked appropriate training. The difficulty lay in the shortage of skilled personnel. In emergencies a lower-level employee would be called upon to do work of a higher classification. She would be trained on the spot rather than in the formal classroom. In a few cases she wasn't trained at all, but left to use knowledge she had accumulated through her own shrewd observation. Then when that particular crisis had passed, the employee was understandably reluctant to step back to a more narrow range of activities. She "knew" how to do the higher prestige task, but her knowledge was considered illegitimate.

In areas where graduate nurses were in shortest supply, it was more frequent to find the practical nurse coming into full recognition and respect. These hospitals sometimes set up their own training schools for such women and it was relatively easy for an ambitious person to advance herself through study and hard work. In other hospitals it was considerably harder to go from the level of aide or nurse assistant to practical nurse. An individual would have to leave her place of employment and spend money and time elsewhere to gain her right to take examinations. Even then she wasn't sure of reacceptance at her original place of employment since sometimes the registered nurses

were suspicious and felt uneasy in the presence of a licensed nurse, not a graduate of the traditional three-year hospital training course.

In all cases known to us, it was virtually impossible to move from the level of practical nurse to registered nurse. An individual would have to start out all over again, taking the three-year course which would mean repeating much of the training in nursing arts she had already acquired as well as getting additional education in theory. The highly qualified practical nurse, therefore, was subject to some frustration. There was no way for her to "advance." We have already commented upon the phenomena of blocked mobility in hospital occupations, and this is just another example of it.

It may be seen that relations between levels can be quite touchy and subject to stress. Perhaps the surprising fact is that in many cases people managed to acquire a friendly and mutually supportive accommodation. The auxiliaries we knew wanted very much indeed to be accepted as part of the medical team. To this end they modeled their conduct to match that of the nurses who worked around them. Sometimes one admitted ruefully that this included learning poor behavior patterns as well as good ones.

You can't help but be like the nurse you work with. If you work on the floor with one who is callous, the first thing you know you find yourself getting callous too. It's a kind of self-defense maybe. Then when you work with another nurse you are ashamed because she has high ideals and you have lost some of yours, and then you try to adjust to her.

While they greatly admired some nurses the auxiliaries dreaded working under others. They would say, "There isn't anything on earth meaner than a mean nurse."

The thing that hurts most of all is when the nurse doesn't do right by the patient, if she lets the patient suffer unnecessarily. You know, sometimes the aides are a lot closer to the patients than the nurses are. The nurses sit at the desk and write the charts and we are out taking care of the patients and giving them baths and making their beds, so sometimes the patients tell us things. For instance one woman will tell you that she is in very great pain and can she please have something to relieve it. Now maybe you have worked with that patient for many days and you know that she is not the kind to complain if she isn't really in bad pain. Then you go to the nurse and say as nice as you know how to, that Mrs. So and So is in great pain and couldn't she please have something to relieve it. Well, if that nurse turns on you and

scolds you for bothering her, or if she says something mean about that patient fussing, it is almost more than you can bear.

It was routine for aides to suggest that they did all the work while the nurses sat around resting, but one aide advised us not to take this too seriously. She admitted:

I really do feel that they push work off on us, but maybe I'm wrong about it. . . . They don't do it so very much, just once in awhile. Maybe one of the reasons I feel that way about it is that they can tell me to do things and I have to do them, whereas I can never tell them anything. That means if there is any pushing off to be done, it is always in one direction and never the other one. You're just in a position where you can't talk back.

Many aides, and other rank-and-file employees as well, suggested that it would help if they had regular meetings among themselves to discuss their problems as a group. One aide said wistfully that she thought it would be much better if the aides met alone, without any nurses present. She said, "We can't help but feel their superiority." We knew of one meeting where a graduate nurse came to represent the administration. She reported afterward that she was amazed at the amount of hostility the aides showed toward nurses in general. It is our guess that the quotation above is an accurate reflection of a common sentiment. It isn't that they dislike nurses, but that they dislike being on the receiving end of orders all of the time. This group evidently used their meeting to let off steam.

We have no doubt that the organizations for practical nurses serve similarly as an outlet for aggression. The practical nurse is proud of her achievement and anxious to be recognized as a part of the medical team, but for a time she continues to suffer ostracism by the graduate nurse, in many places, who just isn't ready yet to accept the practical nurse as a bona fide partner in the fight against disease.

The graduates, in their interviews, often expressed appreciation for the auxiliaries and commented that they couldn't have survived the war years if these women hadn't come to their rescue. It was not unusual, however, for the nurses to express feelings of superiority even while they murmured praise.

Some of them are just wonderful. They can be a big help to you. Of course, they don't have the same idea about things that we do. To them it is just a job.

That theme ran through many of the interviews. They implied that the auxiliaries worked mechanically and for a wage, without the sense of high calling which a good nurse brought to her tasks. Our own feeling was quite different. While the auxiliaries had limited training, they often had sympathy in abundance. In fact, one sometimes wondered whether they didn't have too much of it for their own good. It was our impression that new aides acted very much as new student nurses did. A few grew callous with disconcerting swiftness, of course, but others agonized over the suffering around them and were on fire to do something about it. We sat with such an aide through one lunch hour, as she smoked cigarette after cigarette and pushed her food aimlessly around the plate with an idle fork. One of her patients had died that morning. She said:

The nurses said they would tell me this afternoon what it was that they were doing to Mr. Black. It was awful the way they were sticking needles into him, but they said it had a purpose and they would tell me about it when I got back from lunch. Lunch, huh, who can eat? . . . You can't help but get down when they die like that. One old man was very fond of me, he really was. I took care of him when he first came to the hospital and I fed him and looked after him every day. When he got delirious he would yell, "Sue-Ellen, they're killing me." He died when I was off duty. I felt awfully bad about that because I wasn't there to help him. . . . Well, guess I better be getting back. Gee, I'm so tired I don't know how I'll get through the afternoon.

Where the nurses were indifferent or cold toward them, the auxiliaries turned more noticeably to their patients for fellowship and appreciation. Some of them, like the orderlies, led lonely lives and the hospital filled a need on their part. They turned the warmth of their hearts onto the patients. One of the kindest and most hard-working persons we met was an aide who commented:

You have to be interested in this work to really like it. If you look at it as if it were a machine on an assembly line, it isn't any good. Lots of times I think to myself, "These are my own." I wouldn't do any more for my own than I would do for these.

Possibly some of the "callous" behavior one sees in hospitals is an important defense mechanism against too great emotional strain. It is sufficient to note here that the impulse toward humanitarian service is present at many levels of hospital personnel and cannot be assumed to be the monopoly of any one.

Folk Medicine

Many employees stated that an important motivation behind their working in the hospital was their desire to learn something about the medical arts, particularly those portions which could be used at home in taking care of the family. This was often cited as a reason for working hard and "getting ahead."

Glenda used to be an aide too, and now she is an assistant and can do all kinds of things that are helpful around the house, taking care of your own family. So far the work *we* do isn't of any particular benefit at home; mostly it is a kind of light housekeeping. I'm hoping to get into the nurse assistant training course myself next fall.

Can a person be criticized for seeking knowledge and skill in such an important area? We found that employees at virtually every level were "picking up" information concerning health and disease, and this was just as true in the front offices as on the back staircase. The hospital grapevine always carried items about medicine and new cures. Employees were carrying this home and making use of it variously, according to their individual capacity, interest, and ethical standards. In some instances such lore was simply a conversational help, a way of seeming to be conversant with scientific advances. In others the employee was playing the role of amateur physician. For example, one intelligent albeit uneducated maid who lived in a poor section of town was quite obviously soaking up information like a sponge. Fortunately for her neighbors, her observations were shrewd and careful:

The family kid me about it a lot. They ask me who I think I am, a doctor or a nurse. However, I notice that they do what I tell them to do just the same. You know you pick up all kinds of things. For instance, there is a Polish lady who lives across the street from me who has some kind of skin trouble. Well, I looked at it and I told her what they do here at the hospital is to boil down boric acid solution. They just boil it down, using regular water, and it gets a thick gooey mess. It is awful messy stuff but still it seems to work. So, she tried it and sure enough it cured her hand right up. Then there's another woman in the neighborhood whose skin breaks out all the time and she was asking me what I thought about it and I told her how one of the nurses on my floor has the same trouble and said it was her nerves. Now you wouldn't believe that, would you, that your nerves could do that? Yet, that's what she said, so I told the woman that. You see, you pick up

all kinds of things like that around here and a lot of them you can use at home too.

Hospital administrators and medical personnel may feel strongly that it is part of their job to protect the community from dangerous half-knowledge and well-meaning but misinformed persons. This belief on their part has its influence in shaping the division of labor among employees since it represents still another reason for guarding the jurisdictional lines. We only saw one instance where this was carried to the extreme for forbidding nurses' aides any access to medical records. In this case they were not even permitted to listen in at change of shift to the nurse's report, hence they didn't know what diseases their patients were suffering from. This was supposed to protect the privacy of the patient (by preventing gossip about his ills), and also to prevent the misuse of medical knowledge. We saw evidence that the result was sometimes a dangerous ignorance. For example, one aide was horrified to discover that a patient she was tending had a tapeworm. In this case she was told about it by the physician.

He said that if I handled this woman's bedpans I wanted to be sure to wash my hands very thoroughly, really scrub them with a brush and then rinse them off in alcohol. . . . I felt terrible because here I had been taking care of her for days and nobody had ever told me about this before. . . . They are always asking you to do things around here and then you find out later that they were dangerous and evidently it never occurred to them to tell you how to protect yourself. . . .

Another pathetic story came from an aide who had ignorantly wandered into the room of a polio victim when she was searching for a pillowcase. She said that all that night she kept getting up and moving her baby's arms and legs to make sure he wasn't paralyzed yet. It may be seen that this woman, a hospital employee and mother of a child, had no knowledge whatever of the symptoms of this dread disease and lived in terror of it.

How can a hospital satisfy the hunger for knowledge on the part of its employees, giving them the necessary facts concerning their own health and hygiene, and at the same time protect them and the community from the evils of folk medicine? We have never seen this problem seriously tackled. Perhaps there is no perfect solution at present, although it has been suggested that the public may be developing ways to protect itself. We seem to be increasingly devoted to "expertise" and distrustful of the amateur, the decline in midwifery being a case at

point. One may be permitted to wonder why public education in preventive medicine and elementary nursing care couldn't begin with hospital employees. Their natural curiosity could be thus utilized to the advantage of the workers and of the hospital too, if education were presented as a reward for hospital service. The employees already see it that way. The problem is to make legitimate and aboveboard what has already been going on surreptitiously.

Summary

The nursing auxiliary is comparatively new in many hospitals and she is still in process of being accepted as a necessary and important part of the staff. We found the same sort of status difficulties among the auxiliaries that were found at other levels of the hospital among relatively new groups such as technicians and social workers. The new occupational groups were ambitious, anxious to please, and hungry for recognition in their own fields.

Among the auxiliaries could be found all types of people, from the mature and well-adjusted local woman who was striving for a permanent place in the hospital, to the transient who just paused long enough to decide where to go next. Among the latter group some supervisors found employees a trifle *too* colorful. Coming as they did from different levels of society than her own, she found them a challenge to her understanding. These employees frequently needed the support of a sharply defined job description, since to the inexperienced any demand made of them seemed an imposition unless they had proof that it was just. They pleaded for their supervisors to be "fair," and to recognize fairness they had to know what the rules were.

Everywhere the need for skillful selection, placement, and training was recognized, but methods for accomplishing this were still in process of being worked out. We saw training programs which encouraged the ambitious and gave incentive to those at the bottom of the skill ladder. We also saw the problems which arose as new levels were added, when some employees moved up and others stood still. We have indicated how strain will be found to exist between levels, each one striving to encompass the privileges of the next, and of the need for firm supervision to hold jurisdictional lines. The role of the graduate nurse as pace-setter, the one whom the others imitate, has been detailed.

Finally we have called attention to the danger and fascination which employees encounter as they hover on the edge of scientific medicine;

their desire to be of service to patients and to their families at home, and the way that desire sometimes becomes mingled with a hunger for the prestige which goes along with the practice of the medical arts. The emotional involvement of human beings in the healing process is the beauty and terror of hospital employment.

MEN AT WORK: A STUDY OF MALE EMPLOYEES IN THE HOSPITAL

STATISTICS ON OCCUPATIONAL trends in the United States reveal some surprising facts which are of interest to hospitals. One might have supposed that the age of the assembly line would show a decrease in the numbers of highly skilled workers and an increase in unskilled ones, but no. What has happened is that the craftsmen have gained slightly in numbers, the semiskilled groups such as machine-tenders and clerks have boomed, and the biggest drops have occurred in the categories of farmers and laborers. In 1910 one-fourth of all workers were classified as laborers. In 1950 this figure has dropped to one-tenth! ¹ The unskilled worker is rapidly becoming the vanishing American.

Workers who are classified as unskilled today fall mainly into two categories. The first cluster are those who are fifty years of age or more. These include the few remaining immigrants, the handicapped, and persons whose lives were blighted by the great depression and who never regained social position. The second and much larger group at the opposite age level is composed mainly of teenagers, youngsters who haven't really gotten started yet. They think of themselves as on the road to better things. We are a nation of strivers, people who have every expectation of "getting ahead in the world" because in our land so

¹ See *Manpower in the United States*, edited by William Haber, F. H. Harbison, L. R. Klein, and G. L. Palmer. New York: Harper & Brothers, 1954. pp. 86-87.

many people have. If a person isn't making progress, he feels that something is wrong.

These facts, encouraging though they may be, represent problems to the people who run our personnel offices, particularly where there are a number of "dead-end" jobs to fill. The hospital is a place in which many jobs at least until the present were in this category. The kitchen, housekeeping, maintenance, and the nursing department have been rife with them. Today the number of applicants looking for such positions is diminishing and those who do apply are not content to remain unskilled. They want to know what promotional opportunities are open to them, and turnover is immense in jobs where such opportunity is lacking.

The transition hospitals have been making between ancient and modern personnel practices is nowhere more clearly revealed than in its policies toward unskilled employees. Traditionally hospitals kept their costs down by hiring workers at less than prevailing wages. In order to get workers at such low rates, they accepted the otherwise unemployable: the handicapped, the aged, the derelict. Hospital employment came to be seen as a form of charity, a way to give a modicum of self-respect to people who could not find work elsewhere. Social agencies and well-meaning individuals acquired the habit of directing such persons to the hospital for jobs. Here they found housing and meals as well as some medical care and oversight. In other words, these jobs gave them a haven in life. They were more than just jobs, but at the same time they were something less than just jobs too. Hospital employment acquired the stigma of charity. To accept work there came to be seen as an admission that you couldn't get work anywhere else.

The modern hospital is trying to change this situation. Hospital personnel policies are being revamped and brought into line with those of business and industry. In many places the policy of providing lodging to unskilled employees is being abandoned, and often the provision of meals is being sharply reduced if not dropped altogether. Employees pay fees to the Blue Cross just as workers do elsewhere. They are therefore not so dependent upon the hospital for free care, although some medical oversight is still given. As the old "fringe benefits" are taken away, wages should logically rise and actually they *are* rising. However, progressive administrators as well as employees agree that they aren't rising fast enough to attract efficient workers. The cus-

tomary attitudes of the community toward hospital employment continue to prevail and customary patterns of relationship within the hospital are hard to outgrow. It isn't as easy to change attitudes as it is to change policies.

Meanwhile the hospital suffers serious handicap in its competition with industry for efficient workers. The oldtime employees continue on its payroll partly because they are so desperately needed, and partly because in many cases there are no pension plans to ease their retirement.² New employees learn patterns of behavior from old ones, or else get disgusted and quit. The result is a period of slow change. Whether it is faced with hope or frustration depends upon many things, as the following data may reveal.

This chapter will compare several groups of male workers: the old-timer who is not going any place, the younger one who is striving to, and the craftsman who has special skills and is proud to use them.

Unskilled Workers—Old Style

Many persons in the hospital spoke to me of Demetrius. He has worked here longer than anyone else and must be close to eighty years of age. Demetrius told me that he first came to the hospital as a patient and when it came time to pay his bill he asked for a job so he could work it out. That was thirty-six years ago now and he is still here. He said that at first he couldn't understand English at all. They would ask for a broom and he would bring them a bucket. Patiently they would show him what a broom was and next time he wouldn't make that mistake. He always did general handy-man work, he explained, anything that needed doing. Now he takes orders only from the "big boss" [the administrator]. He goes directly to her each morning after bringing in the ice and supplies, and she gives him orders for the day. Demetrius told me that he doesn't allow anyone else to order him around. If they call him, he hides. He has a secret hiding place in the basement and told me with glee that nobody can find him there. In the old days he worked terribly hard, he said, all day long and he was on call at night, too. Now he just works as hard as he wants to. The hospital has always looked after his needs, they would do "anything" for him. "This place doesn't pay very much," was the way he put it, "but you always have the job; good times, bad times, always make out O.K. Other places you work hard, make good money two weeks, and then you're out of work again. An old Greek like me has trouble getting jobs."

² Hospital workers are only now being brought under the federal social security provisions.

Demetrius seemed unique in that he was the hospital's pet and knew that no matter how decrepit he became, he would still be employed. However, all of the hospitals studied turned out to have their pets. There was always some oldtimer who busied himself with small tasks and who was treated with honor and affection regardless of the amount of work he did.

In addition there were the other old folk who lacked the seniority which protected Demetrius. One hospital had a man who worked in a self-operating elevator whose job it was to see that the car stopped at all floors. Alex was a silent man whose skin was absolutely waxen. In a rare talkative mood, Alex told us that he had been kicked by a horse and had been unemployed for years and as a result his doctor got him that job. Usually Alex said nothing but would discipline his passengers by carrying them beyond their stop if they didn't speak to him with respect he felt his due. One day a prominent doctor got on the elevator at the first floor and said briskly, "Fifth." Alex said nothing and the elevator moved downward. The doctor cried, "I said *Fifth!*" Alex turned to him calmly and replied, "Sure, Doc, but I'm going to the basement." The doctor looked as if he would explode. He glanced at me, then turned his back on both of us and the elevator proceeded to the basement and then rose to the fifth floor, stopping at each floor as it went.

Frank was another oldtimer. His job was to clean the autopsy room. Frank was as garrulous as Alex was silent and had been shifted from job to job within the hospital until this one was found where he couldn't annoy the other employees. Frank told us at least three times about the accident which ended his career as itinerant carpenter. He couldn't pay his hospital bill so offered to work it out. We couldn't get him to compare his job with others he had had. He said cheerfully that it was all the same to him, he didn't care where he worked. He didn't know who his supervisor was, gave us three names, and said it didn't really matter because he didn't pay much attention to any of them. No matter what they told him to do, he explained, he would just smile and go ahead and do what he planned to do anyway. Frank's supervisors thought he was feeble-minded. They weren't sure he even heard them when they spoke to him.

Demetrius, Frank, and Alex are probably representative enough of those who stand at the lowest rung of the hospital social system. For the most part, we found such employees to be kindly folk. They turned

up dependably enough day after day and put in what they considered to be an honest day's work.

The supervisors of such men had their problems. It was, of course, virtually impossible to discipline them and efforts to do so usually resulted in sulking on the employees' part, exasperation on the part of the supervisor, and general hilarity among onlookers who had experienced similar problems themselves. There was no way to provoke a spirit of striving here, no hustling for advantage. The only thing which seemed to motivate them to greater effort was affection. These older people needed more than just patience. They needed warmth and understanding. They liked someone who could kid with them, who would put up with their bad days and in return expect extra service on good days. In other words, the workers wanted to be responded to as human beings. They enjoyed feeling a degree of autonomy, a freedom to set their own pace and to do things their way. Where they were accepted on their own terms, to our observation, both sides seemed to make out well enough. The worker got his pittance in wages and management got its pittance of labor in return. Anything more than that was a direct outgrowth of affection.

Orderlies

The work of the orderly differs from one hospital to the next. Usually it includes such chores as caring for the simpler needs of male patients and transporting of patients to and from such departments as x-ray. Sometimes it also includes work involving considerable skill, for example assisting in the application of casts and braces. Some of the men who took orderly jobs were found to resemble the older workers described above. They put in their time and called it a day. Others reacted similarly to the ambitious young strivers and were eager to advance themselves and to learn new skills.

The orderlies were among the most interesting and colorful workers we studied. They came from a wide variety of backgrounds and in some cases were part of the migrant labor group which roam gypsy-like across the continent doing any work which comes to hand so long as it leaves them free to roam again when the mood strikes them. One such man explained:

You see, at one time this kind of job was the travelers' heaven. The majority of fellows who were orderlies were drinkers, heavy drinkers. That's how I got into hospital work myself, and that's how most of them do. See, it's really swell, you can go into any hospital at all, day

after payday, and you are always sure that there will be a job open either because somebody has quit or else somebody is out drunk. I was what you call a periodic drinker. By trade I was a steamfitter and I would work on a construction job for a couple of months and then go off on a binge and I wouldn't be fit to do steamfitting again so I would work in a hospital until I got myself back in shape. Then I'd go back to steamfitting and it would start all over again. Of course, steamfitting pays more. . . . That went on for about fifteen years, I guess. Now I belong the AA³ and I've been working here steady for three years.

Another orderly said he had been an insurance salesman until the depression closed in on him and he retreated into the world of drink and wandering. He told us:

. . . and that's the way it is with hoboes like me. We aren't bums. Bums don't want to work. A hobo will work and save his dough and then go on the lam again until the dough is used up. . . . I've met a lot of very fine men in this work, lawyers, and poets and all kinds of people. It's an interesting thing. Of course, most of them drink but some of them don't drink at all, some of them don't even smoke. They just have itchy feet, that's all, so they keep moving around. . . . You get to know people. You go to a strange city and you'll see a familiar face on the street. Maybe you've been in a jungle with him someplace. You get so you know the jungles all over. . . . Those fellows, they'll pitch in and help each other out. I've done it myself lots of times. You all pitch in and make a stew . . . if another fellow comes along at the last minute and is hungry, supposing he doesn't have any money, that's all right too. He sits down to the Mulligan stew same as you. . . . It's always that way among those fellows. They'll share anything they have, shirts, shoes, anything. I've done it myself. So long as I had money it didn't mean a thing to me; I'd just as soon shell it out to the next guy as not, and they feel the same way.

The orderlies maintained that this philosophy of life was reflected in their work. They claimed that the hoboes were gentle with the patients because they knew what it was to be down on their luck, and pointed out innumerable examples to show that social status meant nothing to them. They would just as soon tend to the needs of a pauper as those of a king. If tips came their way, they would pick them up promptly enough. If none were offered, they shrugged their shoulders philosophically. A head orderly advised us that it was very seldom

³ Alcoholics Anonymous.

he came upon one who was greedy. Evidently they were not motivated by the usual incentives and lived by their own code.⁴

It is, of course, difficult to unravel cause and effect in such patterns of relationship. Did hospitals offer orderlies low wages because they had discovered that money was a weak incentive to make them work harder, or did the inadequate wages produce the casual attitude toward the job? All one can say at this point is that the two phenomena went together, the low pay attracting indifferent workers in most instances. One man put it to us bluntly:

So I went from one hospital to the next getting jobs as an orderly and between times being out on a bender. You'd be surprised. The turnover in those big hospitals is tremendous. The only men they can get to work for them are drunks. I'm not saying they aren't good fellows, understand. I've met a lot of fine fellows who were drinkers and on the bum like me. But just the same, those hospitals could have gotten steady fellows if they wanted them. If they would pay enough wages or give a man some incentive, they might be able to keep them on. A man wants to raise himself. But they would never do it; the fact was, they just didn't give a damn about the men. Consequently, they only got bums to work for them and every payday it was goodbye. The same thing in all the hospitals I worked in and I worked in them clear across the country.

In some cases it was apparent that the older men weren't interested in "bettering themselves," perhaps in part because they were too disillusioned with either their own capabilities or the fairness of management. For example, one man who appeared capable enough informed us:

I could have gotten my license as a practical nurse if I wanted to, but I turned thumbs down on that. You would get your license and then you'd be doing nursing duties along with everything else and for the same money. The more work they get out of you, the better they like it. You just have to be on your guard. When I come into a new place, I say to them, "Now look—no cleaning and no nursing!" If that is agreeable to them, I work; otherwise not. They know I can always get work at another hospital, so that is the way it is.

At that particular hospital the orderlies with practical nurse licenses were getting five dollars more a month than those without, hardly

⁴ For further discussion of incentives, see Allison Davis, "The Motivation of the Underprivileged Worker," Chapter V in *Industry and Society*, edited by William F. Whyte. New York: McGraw-Hill, 1946.

enough to spur one to very great efforts. Other hospitals were doing considerably better than this, not only paying substantially more but differentiating between the duties of the two groups. This appeared to be of considerable importance, for where no differentiation took place, the men complained that the practical nurses "thought they were something" and reneged on their share of the more routine tasks.⁵ It was common to find throughout the hospital that persons closest to each other in the status hierarchy tended to compete for advantage and to irritate each other accordingly. It seemed to work better where clear distinctions were made in their work assignments.

When one talked to the younger orderlies, a difference in outlook promptly presented itself. For the present, at least, these youngsters were still striving to find opportunities for self-advancement. Like the nurses' aide, the nurses' assistants, and the practical nurses, these orderlies kept trying to improve their position. They would take it upon themselves to do work of a more technical nature than was assigned them. They kept hounding the personnel office for promotions—whether in pay or in job title or in actual duties. Many of them would try to impress the interviewer by referring to books they were reading or technical courses they were taking in correspondence school. Sometimes their frustration was heartbreakingly evident. We met several veterans who had encountered difficulty in adjusting to civilian life. One of them had tried his hand at many things.

I like hospital work best, definitely. I like to help people, to know that I'm doing for them some of the things I would want done for me if I were sick and down and out. Here I can meet strange people and get along as if I had known them all my life. In the factory, why, I didn't even get to know the man who worked at the next bench. In the hospital it comes natural to meet people from all walks of life. For instance, one of the members of the Board of Trustees was upstairs and I took care of him. I didn't even know who he was and I talked to him the same as I would talk to any the patients on the men's ward. When I found out, it didn't make any difference. I still treated him the same way. . . .

John was applying to get back into the Navy as hospital corpsman. He explained:

In the Navy I have a chance in life whereas if I stay as an orderly here I will go up to a certain amount of pay and that's where I would

⁵ The practical nurses were given what the men termed "nursing duties" which included such things as catheterizations, bladder irrigations, etc.

stop. There is no chance at all for advancement. If you work at it for fifty years, you would still be a plain orderly.

He had it all figured out:

In the Navy you do just about what the student nurses do around here. You have eight hours of schooling a day for four months and then you work for so many weeks and you can take a test. Then you have more schooling and finally you have your final exams on which your mark depends. After that you are assigned to duty in some hospital and after a certain amount of experience more, you are eligible to take another examination for pharmacy mate, third class. You can work right up to Chief, and that's as high as an enlisted man can get. He's in charge of all the enlisted men. It takes ten to twelve years to work your way up to Chief in peacetime.

John may or may not have had the details straight, but his motivation was clear enough. He wanted the chance to work his way upward. Status meant a lot to him. Even waiting on the member of the Board of Trustees was to him a great thing. He didn't want to remain "just a plain orderly."

We came upon other men like John among the younger group. Some of them were what the orderlies called "naturals," meaning healers in the old-fashioned sense, people with a natural bent toward the healing arts. They told us of how they had always wanted to be doctors, then later revised their goals to being nurses when financial limitations ruled out their first choice. Some, like John, had been given a taste of medical work in the armed forces and felt a strong satisfaction in taking care of the ill, but when they tried to make it a life's work they soon found that there was virtually no way to work up from the bottom. As married men they felt unable to take three years off for basic training, and they claimed that the practical nurse license was an economic snare and delusion unless you were willing to take private cases in people's homes, again difficult for a married man. We found that where this ambitious handful couldn't make themselves a respected part of the medical team the entire group of orderlies felt frustrated and resentful. For instance, one said bitterly:

I don't know what's the matter with them. I think they must be crazy. After all, an orderly is an important person. . . . If they would pay it [a living wage] they would get good, steady men. . . . Take Bill, now he isn't a bad egg at all. If they had any sense at all, they would pay him a decent wage and give him some incentive like they do in the V.A.; pay him so much to start and if he makes good after three

months, pay him a little bit more and give him duties a little bit more advanced. . . . You'd feel like you were getting someplace. As it is, you have no incentive whatever. You do what you can to help people, but you've got no reason to put forth special effort.

This same man admitted, later in the interview, that it was almost impossible for the smaller hospital to arrange such promotional opportunities. There just weren't enough jobs for them to be built into a ladderlike structure. There would be one position as "head orderly" which involved the additional task of assigning the other men to specific floors and shifts. Aside from this the men shared much the same duties and the only difference in pay came from seniority in the job.

We found that even in such instances the men appeared to find gratification in special training. For example, in one hospital a young resident in urology on his own initiative set up a class for them concerning the treatment of his cases. Both the nurses and the resident expressed the belief that work on the urology wards improved as a result, and the orderlies commented appreciatively on it, saying that it made their work more meaningful.

We had no opportunity to observe formally organized training courses. The educational efforts we saw were on a voluntary and mostly informal basis and there may have been a self-selective factor at work with only the more intelligent men participating in them. At any rate, these men showed an active interest and appreciation in them. These were the orderlies who took their work most seriously, saying that an orderly's job was important and that it deserved more attention than most hospital administrations were giving it. It seemed to us that along with their desire to learn was a desire for the respect which goes with education. These men were sensitive about being respected. They greatly admired one interne who went with them on ambulance calls and gave them tips on first aid. They said he "treated them like human beings," meaning as equals and friends. They would do anything for him. They also knew with perfect clarity who the snobs were among doctors and nurses.

Typically the orderlies seemed to get comfort from their relations with the patients. One of the younger men who was hungering for recognition had this to say:

It bothers you if you work hard and still they aren't satisfied. Oh, you might get some encouragement from the help but not from the people

who run the hospital. Still, when you get a compliment from your patients once in awhile, it makes up to you. Like today, for instance, I had Saturday and Sunday off and every one of the boys in the medical ward asked me where I had been and what I had done. It makes you feel real good.

These were lonely men. We saw many instances where the orderlies hung around after working hours to play games with patients, to run errands or do special services such as barbering for them. Of course this provided them with some extra cash in tips (even where tipping was forbidden) but we suspect that they were getting more out of it than money. *Their private lives were often empty and meaningless* and they needed to feel wanted. The same factor appeared related to the successes we witnessed on the part of the Alcoholics Anonymous. One orderly commented:

You know, we work taking care of each other, that's what my AA membership amounts to. I am able to keep sober because I am so busy helping people out. It is the only reason I ever found for keeping sober.

The most successful orderly group we observed was given leadership by a man who had been an engineer and a hobo himself. In fifteen years of hard work he had built a team of twenty-four (including women as well as men, incidently). He told us that he estimated 70 per cent of them to be permanent workers, 30 per cent drifters. When he had started, there had been almost complete turnover every payday. Peter attributed his success to two major factors. The first was selection. He picked his men carefully, encouraging the more promising ones and dropping the others. Second, he tried to meet the men halfway, as he put it. Peter did everything in his power to build up and protect the self-respect of his group. He said he liked to see them "proud and spruced up" and would lend them clothes and money to get started. He said this was not only for their own sakes but for the morale of the entire group. He understood the loneliness of the men, having been in their shoes himself, and did what he could to assuage it, encouraging their participation in community activities and taking them out to dinner at the homes of his friends.

These orderlies were respected. Throughout the hospital we came upon nurses who would comment that they had never known orderlies who could be so helpful. There was an especially cordial spirit between the orderlies and the student nurses, each group thinking that it was looking after the other one. The girls saw to it that the older men had

warm coats in the winter, and the men "showed the girls the ropes" when they came into a strange department for the first time.

This situation was not just marked with sweetness and light, however. Peter would reprimand them if they did wrong, and his judgment was sure. He gave justice to the men as well as respect. He saw to it that their duties were carefully defined. They were not required to do cleaning nor did they do "nursing duties" unless they had licenses as practical nurses, in which case they were paid substantially higher wages. As a result the men did both cleaning and nursing duties upon occasion, pitching in of their own free will when it was urgent that they do so. It was made plain to them and to everyone else that they were "doing a favor" and when possible, they received extra pay; for example, when they helped out across department lines. They became a kind of interdepartmental duty squad called upon to serve in many places but always with a clear understanding that they were entitled to a just return. Peter told of the way he got them to scrub garbage cans, for instance. This was held up as a reward and it provided extra pay. Peter went along with the first group to do this chore and set the attitude for the whole group. After that the men volunteered for this job. Peter would always go to bat for his men if he felt they were being exploited, and it didn't have to happen often for the lesson to stick.

For some reason it is usually the private duty nurse who will try to get an orderly to do the dirty work for her. You soon catch on to them and know which one is which. You also get to know the orderlies and know whose word can be trusted. It is only occasionally that you find a nurse taking advantage. Then the men will refuse to work for her. I usually try it out for a day or so, give her the benefit of the doubt. Then if I'm convinced she is chiseling I'll go up and speak to the nurse personally and tell her to lay off. I might assign another orderly to work with her temporarily to see whether they can get along any better. Somehow I never have any trouble with the doctors. They are very decent to the men. When I need clothes for them, it's the doctors I turn to and if they have anything at all, they always give it to me.

One possible factor in the stability of this department may have been the fact that these orderlies had their own quarters, a pleasant sunny room where they relaxed and played cards during the slow part of the afternoon (visiting hours) waiting for calls which came in over the telephone. Peter had his desk there and thus could watch to see that unfair advantage was not taken of this privacy. The men, like house-

keeping maids, worked all over the hospital in the course of the day and were surrounded by higher status people. Almost anybody could give them orders. Their private room must have seemed like a retreat to them. The easy informal contact that it made possible among them *may have helped build up the team spirit we saw in evidence among them.* Of course, they bickered sometimes as people do anywhere, but they were unusually cooperative about such things as exchanging days off and giving holidays to the married men so that they could be with their families.

In summary, according to our observations the orderlies were people who put a high value on personal freedom. They liked to have their work clearly defined so that they and everyone else knew where they stood, which duties were rightly their responsibility and which were not. At least some of them very much appreciated the chance to learn and to advance themselves, *provided the additional responsibilities were adequately rewarded.* This was especially true of the younger men. All of them appeared to thrive under a firm leadership which commanded their respect and which defended them against the onslaughts of others.

Other Semiskilled Workers

A great deal that has been said of the orderly and the oldtimer, *fits equally well in the cases of men who do other forms of semiskilled work.* There are jobs in the laundry, for example, which fit into this category. The washermen come somewhat closer to the class of skilled craftsmen, perhaps, but the fellows who sort the soiled linens, those who trundle the clean laundry around the hospital, those who help empty wet wash out of the big hoppers, show attitudes which approximate *either those of the oldtimers or of young fellows discussed above.* An older man may accept his lot philosophically and make the best of it. A younger one has more tendency to be frustrated unless he can see that his work helps to train him for other jobs, or at least opens the way for him by helping to prove his general reliability and character. The same thing is true of furnace-tenders in the boiler rooms, and of such kitchen helpers as pot washers and dishwashers. If there is a definite skill involved, or a piece of expensive machinery to be tended, the men can maintain some self respect. Otherwise they soon feel degraded and become restless. In addition, where a man works alone he may feel the lack of fellowship which sometimes helps to compensate for an otherwise boring task.

Skilled Workers

The hospitals studied contracted out such work as major architectural changes or repairs, painting, reconditioning of the heating plant. Such jobs were supervised by the contracting firm and the workers were members of craft unions. Maintenance repairs and upkeep were assigned to hospital employees who were classified variously as "the engineering department," "building and grounds," "maintenance," and so on. These men did carpentry, pipefitting, plumbing, electrical engineering, refrigeration, and tended the heating plant. They varied from chief engineer down to furnace stokers but many of them fell into the highly skilled craftsmen group. Some of them still carried their union cards but were doing such a variety of things that membership in a particular craft association didn't mean the same thing any more. However, their wages came closer to union rates than did those of many other hospital employees. Typically these were sturdy family men, homeowners who seemed to spend most of their time fixing up their dwellings and enjoying their families and grandchildren. Their lives presented a sharp contrast to the insecure and lonely orderlies.

We found many older men in these jobs. Some of them had small pensions from industrial jobs which they were keeping quiet about. Some of them boasted that they really didn't need to work but did so to keep busy and active. Others, of course, were dependent upon the wage they were earning.

There was Mr. Deasy, a man of seventy who looked no more than fifty-five. Mr. Deasy kept his hat on all day, took the interviewer around and proudly explained every boiler and gauge and stressed how important his department was to good patient care. Mr. Deasy was proud of his ingenuity. He told tales of faulty oxygen equipment which he fixed, of gadgets he invented to meet special needs.

Then there was Joe, a man of eighty who looked every bit of it. Joe had thick glasses and said he had been almost blind until the hospital had removed his cataracts. He was terribly grateful to the hospital for taking care of him, he said. For a long while he had to feel his way around but now he sees fine. Joe is a master electrician and Mr. Deasy told us privately that the hospital could never afford to pay him the wages he once earned in industry but with his bad eyes and advanced age he could no longer get industrial jobs.

Paul was a younger man, perhaps fifty-two. He had started at the hospital as a coal shoveler during the depression when jobs were hard

to get. From there he had worked himself up by taking correspondence courses and studying at the vocational high school. He took city examinations until at length he achieved the classification of first-class engineer. Paul said he had industrial jobs off and on, mostly assembly line work, and it bored him stiff. Here he had endless variety; a chance to handle steam, to work with electricity, to repair plumbing. He never knew from one minute to the next what would crop up, he said, and he loved it. He kept reminding the interviewer how responsible his job was, that sick people must have regular and dependable heat and light and refrigeration.

Tom stressed the lack of pressure. In industry, he said, the boss was always after you to speed things up. Here you were free to puzzle each job out for yourself doing it your own way at your own pace. Once the boss saw that you were reliable, he let you alone. Tom brought out pictures of his children and grandchildren. His son was a fledgling architect and one of his girls was studying to be a nurse.

Jim was a retired carpenter who worked because "I would go nuts sitting around the house." He claimed to have highly profitable investments and was threatening to quit the hospital job in order to relax awhile. When the hospital took him in earnest and hired an under-study for him, it just about broke his heart. He came to us tearfully and said:

My dear, they've hired a carpenter. You know darned well that a carpenter can't do all the work I'm supposed to do. Why, I fix the plumbing, I fix electric sockets, I change light bulbs, I fix typewriters. I do any darn thing that needs doing.

In most hospitals these workers have shops in the basement. Their work takes them all over the hospital in the course of a day but they can always go back downstairs and that's where they usually prefer to bring the work when it is possible to do so.

There were, in general, two parts to their work. One was termed "preventive maintenance" and consisted of routine checks to make sure that equipment was in good working order. This was often divided among the men in a way which gave each of them his own area of responsibility. The other part of the work was "remedial repair," or service on demand. Obviously this kind of task was difficult to schedule. Requests came in on the spur of the minute and the men had to respond fairly quickly to them. Many concerned petty breakdowns, a light bulb which burned out or a plug whose wires became

unattached. Since amateurs could do damage to electrical and refrigeration systems, however, hospital employees were trained to call in the experts even for small things such as these. In former times, we were told, requests for service were made verbally. Today in all of the hospitals studied they came in written form, either by formal requisition slip or over a teletype machine.

In all of the hospitals the official policy was "first come, first served." In none of them was this strictly adhered to, and how could it be? In a hospital exceptions could always be made in the name of an emergency, and what an emergency consisted of depended upon the person defining it. For the most part, the men themselves decided which jobs to tend to first. While relations between them and the departments they serviced were usually good, exceptions occurred and the human relations of the entire hospital could almost be charted from this department alone. For example, we were told:

Most of the department heads are really very easy to work with. Sometimes you have to keep them waiting, but if you explain the reasons they are sensible about it. You just have to size them up. Now Miss Peepers is very moody. She can be nice as you please but other times she gets agitated and insists that you drop everything and come on the run. The men got used to her after a couple of false alarms. They would say, "Oh, don't pay any attention to her, that's just Miss Peepers for you." Then there is Miss Price, she's so darned nice that the men will hop up there at the drop of a hat just because they are so fond of her.

One man commented:

That head nurse thinks we don't have any other work to do but hers. Now she wants all the bedside tables covered with linoleum. See, she is new on the job and you have to make allowances. When they are just starting out like that they want everything perfect, so we try to do everything we can for her. I put one of the men full time on her floor for a while. That way if any complaints are made I can say, "Now look, we gave you a man full time and that's as much as we can do."

Occasionally one department head would feel underserved and complain to the administrator or to the head of the maintenance department. In such a case it wasn't difficult to right things again. Either man would arrange to route all service calls across his desk for a time or else check on them after the fact, just to get them regulated appropriately again. Putting things into writing has its advan-

tages, especially when they can be stamped on a time clock and checked on later.

For the most part, the men knew their business and soon learned which calls had to be answered promptly and which could be deferred. The head of one such department remarked:

They are all steady, reliable men who know their work and that's the kind you have to have in hospitals like this. Most of their work they have to do on their own anyway; you can't be watching them every minute. They wouldn't like being watched and if they needed it, we would have to fire them.

Being watched, particularly by doctors or nurses, was sure to bring on trouble. Nothing outraged a skilled craftsman more than to be given orders by the wrong person.

You can't help but get sore at some of the nurses. Every once in awhile you run into one who tries to show her authority over you. Actually they have no authority at all. I don't know whether they think they are better than you are just because they have that white cap on their heads or what it is, but they sure like to push people around. What do we do? Nothing in particular, just keep them waiting.

The same sort of problem occasionally arose with doctors. We were assured repeatedly that most doctors and nurses were helpful and considerate but a few "had to be put into their place." For example, one doctor kibitzed a plumbing job, perhaps with the best of intentions, only to be told forcibly:

Look, Doc, so far as I'm concerned you can go straight to hell. Now leave me alone. I'm working.

In this case the doctor went straight to the administrator but received cold comfort there. He was told, "Well if Jones said that, he probably had a reason." The next day the administrator "happened to drop by" the maintenance office and interviewed Jones. Jones explained that he wouldn't tell the doctor how to treat a patient so why should the doctor tell him how to fix a pipe? The administrator nodded and replied, "I figured you had a reason" and let it go at that. It seemed that the pride of these craftsmen was recognized as an important quality and management helped them to resist any action which demeaned it.

Like other employees these workers put a high value upon good

relationships with doctors and nurses. They spoke appreciatively of their friendly contacts:

Some of the doctors are very nice to us. There's Dr. Henry; he always says hello to you no matter where he happens to meet you. Same thing with Dr. Weiss and Dr. Smith. Do you know Dr. McDonald? He's a nice young fellow. He came down here one day and told me that his wife wanted him to fix up some kind of pole for her laundry. So I told him what kind of pole to get and lent him my poledriver to make a hole in the ground and he came in the next day and told me it worked out fine and his wife was delighted. Since then he always speaks to me when we meet in the hall.

Of course, they're not all like that. Some of them wouldn't say hello if they tripped over you. Now you take Dr. Zeigler. He came down here once and asked Al to fix something that belonged to him, so Al dropped his work and went ahead and fixed this thing. Zeigler was nice as could be, stood around very friendly and chatted while Al fixed this thing. Well, Al says he met him up in the hall next day and the doctor walked right by him as if he had never laid eyes on him before. Al says he has met him lots of times since then and the doctor never lets on he recognizes him. Al said to me, "What do you think ails him?" I told him, "I don't know, Al, maybe some of these doctors think they are better than we are. Just don't pay any attention to him."

Among these skilled men, then, one comes upon persons of marked pride and responsibility. They are aware of the dependency of the hospital upon their conscientious work. The pace of their work is set by the erratic flow of requests, in many instances, and also upon their own judgment. Typically they seem to resist pressure from "outsiders" and require little supervision. In our experience their immediate supervisor worked along with them, setting an example of working without stint when things were needed and cooperating in good spirit to overcome a difficulty. We did not encounter any tensionful departments, although they may of course exist elsewhere. In the hospitals we studied, these men provided their own fellowship within their group. They worked partly within an enclosed space, their own workshops, where they had their easiest and most friendly relationships. They also worked throughout the hospital where they were surrounded by persons of professional status, but they brooked little interference from them. These were long-term employees, usually of local origin, and were highly respected by top management.

The Lone Wolves

In addition to the groups already mentioned, there were other craftsmen at work throughout the hospital. These included such persons as skilled laundrymen, barbers, ambulance drivers, men who tended oxygen equipment, and so on. Sometimes these jobs were given to drifters whose characteristics matched those of the orderlies. At other times the men resembled the maintenance department crews and had special training which enabled them to achieve dignity in their own right. In some places it seemed to be up to the individual to achieve his own status but it wasn't always so simple. Hospitals, being tradition-bound places in many respects, often had customary niches for such jobholders and a man might find himself characterized beforehand almost without regard to his native qualities. We saw these workers handled wisely by one personnel department which managed to make them acquainted with one another. Eating their meals together and sharing insights into the hospital and their jobs, they appeared to be bolstering each other's morale and were among the administration's strongest supporters. It stands to reason that a person who feels like an outsider *isn't going to exert himself unduly unless he has an unusually strong conscience.* These men felt they belonged.

The ambulance drivers at this hospital were veterans apparently of the rudderless variety who had tried their hand at all sorts of things before landing this job. They had built it up to the point where they were operating as first-rate technicians in their own field, taking beautiful care of their ambulances, holding first-aid certificates from the Red Cross, and able and sometimes perhaps embarrassingly willing to instruct any green interne in the art of handling stretcher cases. Management encouraged them to look upon themselves as skilled craftsmen, *respecting their judgment and giving them considerable freedom to determine their work organization.*

In other situations men were left to operate on their own with little assistance from management. Like the orderlies, they drew comfort from the gratitude of the patients. For example, one barber really had two jobs. One was to run the official barber shop where his chief customers were doctors and administrative personnel. The other was on nursing floors where he shaved and cut hair for the patients:

The way I look at it, I'm being most helpful when I'm upstairs taking care of the patients. That's my true job here in the hospital, isn't that right? The doctors and department heads seem to think I should be

here in the shop. They are forever calling and making appointments. Well that's all right, but once I'm in here with the door open, people keep coming in and I can't get back upstairs where people really need me.

This barber went on to discuss cases he had worked on, describing the texture of skin and beard of a cancer case and telling of an eye case where the man was confined in a dark room and he had to shave him by sense of touch. He kept saying how fast he worked and what a comfort that is to a sick person who wearies quickly. The barber had been in hospital work for twenty years and said he wouldn't be happy back in private practice any more. This work was much more satisfying to him. Management, to such a man, was a thing which intruded into his busy day. All he wanted was to be left alone with his patients.

These brief descriptions of the kinds of men who work in hospitals may be sufficient to show the complexities involved in personnel management. The needs of people are manifold and are influenced by the kinds of backgrounds from which they come, their attitudes toward their work, the kind of supervision they are accorded, and such factors as the size of the work group they find themselves in and the space and people they work among. The men who seemed to be most content in our experience were the highly skilled craftsmen with their pride in their work, and at the other extreme, the oldtimers who just didn't care very much about anything any more. The restless ones typically were those between, who wanted to rise in the occupational scale and found the way difficult. These appeared to be increasing in number as the unskilled oldtimers died off, and were properly the concern of the modern hospital.

Summary

The hospital faces some severe problems during a period of transition. Hospital jobs, particularly in the unskilled category, have the stigma of charity associated with them. Even where there is no longer any reason for it, the reputation lingers on in the community. Wages are rising but not fast enough to attract competent workers. The task of hospital management therefore is to find adequate motivation for these employees.

We found that the male worker prided himself on his skills and wanted to develop them further. He also wanted a high degree of

autonomy, a chance to work problems through for himself with a minimum of supervision. He preferred to have his work clearly defined so that lines of responsibility and authority were clear.

The successful supervisors were those who recognized these needs and tried to fulfill them. They did what they could to provide "training," officially where possible and informally where it wasn't. They tried to arrange *job transfers for the ambitious workers*, so that they had the feeling that progress was possible. They protected the employees from higher status people by setting an example of respect and by helping to rebuff officious behavior. They made it as easy as possible for the men to find fellowship among their own kind. In other words, they did what they could to provide status and recognition for their men and then let the situation itself provide the motivation. And meanwhile they kept reminding the administrator to keep wages rising.

CHAPTER 13

LAUNDRY AND HOUSEKEEPING EMPLOYEES

A DEEPER UNDERSTANDING of the employees in each of these departments may be gained if they are seen in comparison to each other. There are striking similarities in the kinds of people employed and in the status of the jobs they are given, yet the way in which workers respond to such employment may differ markedly. Laundries, on the whole, seem to have stable personnel, whereas housekeeping departments are frequently troubled by extreme labor turnover. In the few cases known to us where this is not true, recognizable factors are present which seem to explain the exceptions.

The Workers and Their Jobs

Both of these departments have a certain number of positions which require skill or training. Washermen and window-cleaners, for example, may have work histories as craftsmen. Pressers may have been trained in commercial laundries and housekeeping supervisors sometimes have had extensive experience as floor housekeepers in hotels. The hospital has to compete with commercial establishments for such employees. The more skilled jobs are often given to men, as is the heavier work such as the handling of wet wash or the operating of large machines. Much of the work in both departments, however, is done by women.

The unskilled work is given to individuals who have had no previous work experience. Widows, and neighborhood housewives who

want a job close to their homes, will frequently take such positions. Another source of labor supply is the casual laborer who drifts from job to job without gaining much finesse at any one. The employees in this department are thus very much like those described in the chapters "Men at Work" and "The New Nursing Auxiliaries." When such a worker applies for hospital employment, it is often a matter of chance which department she is placed in. She might be equally well assigned the task of laundry folding, sorting or distributing, hall sweeping, or work as a maid under supervision. Such tasks are easily learned and any reasonably intelligent person can master them quickly.

The semiskilled jobs are often filled by upgraded workers who have been around the department long enough to have acquired familiarity with its techniques and ways of doing things. Mangle attendants, hand pressers, and linen room employees often fall into this category.

Both departments have a limited number of supervisory positions, but generally speaking there are many jobs at the rank-and-file level and few at the upper ones, so the opportunity for advancement usually isn't very great.

When categories of workers are compared across departmental lines, it appears that wage differentials are usually slight. Unskilled workers in both departments earn about the same hourly rates. When differences occurred it was usually in favor of the laundry employees, but the interesting thing to be noted is that even when no differences appeared, the record of turnover remained about the same. For example, one hospital paid both its maids and its laundry women an average of sixty-five cents an hour. (The national minimum wage at this time was seventy-five cents, but voluntary hospitals do not come under this law.) The maids averaged one and a half years on the job and the laundry women averaged seven. In the next hospital to be studied it was found that the laundry women were getting on the average a dime more an hour (seventy-five cents) while the maids were getting sixty-five. The maids here had a job tenure of four years¹ while the laundry women averaged seven and a half years. Similarly with the men, the first hospital paid its janitors eighty cents an hour on the average while laundrymen were getting a dollar and a quarter, but their patterns of job tenure resembled those of the next hospital where both groups received approximately eighty cents. In both instances the janitors had worked approximately a year and a half while

¹ This figure was influenced by the presence of two twelve-year employees. Their case (as pet maids) is discussed later in the text.

the laundrymen at the first hospital averaged three years and the second four years. It may be seen that the relation between employment stability and economic incentives was minimal in these departments.² To the best of our knowledge these are fairly representative cases.

Work Patterns and Job Satisfaction

If financial criteria do not explain the differences in job tenure, what does? It was difficult for the workers to put into words how they felt about their employment. Laundry employees tended to talk like this:

I'm not sure why I do stay here, tell you the truth. The pay sure isn't so hot. I guess I just like it because I enjoy the people so much.

Repeatedly that same general and vague statement was expressed, "I like the people," "The people are so nice here," "My boss is a good egg and so are the others." Some said, "Most people here are swell. Of course you got some stinkers any place." But all this didn't throw much light on the situation, for aren't the employees of housekeeping departments nice people too? When careful observation was combined with interviewing, our focus became a little more clear. In the laundry the workers presented a more united front. The observer saw them as clusters of friends with here and there a couple which paired off, whereas in the housekeeping department one saw mostly individuals at work on solitary tasks, and at most pairs of friends or threesomes. It was only occasionally that one came upon a good-sized cluster, and, significantly, they were the employees with longer job histories. Where the workers formed a closely knit group, they tended to stay on the job. Conversely, of course, the long-time employee had more opportunity to build lasting friendships. This is not to imply that clusters have no faults. They may well be harder to supervise, for example. We are considering now only one factor and that is job stability. Where laundry workers did not fit into groups, their turnover was just as great as in the housekeeping department.

² If the reader misses discussion of economic incentives throughout most of this book, it is because hospital records often did not permit a thorough analysis. Hospitals only recently have begun to keep accounts in comparable fashion. In addition, such things as fringe benefits (free meals and lodging) were not written down as part of total earnings until just recently. We did make payroll analyses according to present earnings and were thus able to compare individuals, job categories, and departments. What was missing was reliable historical data and the ability to cross-check between hospitals.

It is by now a well-recognized fact that man is a social creature and finds satisfaction in a sense of belonging, so this particular finding of ours is not unusual. The question to be explored is, what goes into the human situation in the laundry which helps to bring about the formation of a group spirit, and what discourages this from occurring in the housekeeping department?

Considerations of Space

An obvious distinction between these departments is the place of work. Laundry workers typically spend their day within one large room. This room may be divided according to the placement of machinery, however. For example, the big washing machines may be found on one side of the room, the mangles in the middle, and the hand presses on the side opposite the washers. A division of human relationships was found to parallel these divisions, with the press operators finding their closest friends among other press operators, the mangle girls forming a clique of their own, and so on. However, since all work within one set of walls, they all knew everyone else by first name and appeared to have easy conversations with just about everyone else. The distinction was not so much between friends and nonfriends as it was between casual and close friends. Plainly, where people work in close proximity to one another they will have opportunity to talk as they work and therefore there is more likelihood that they will develop ties of acquaintanceship. Enmities occur too, of course, but, as we shall see, a closely knit group can squeeze out anyone who doesn't quite "fit," so in the laundries studied, a basic unity of spirit was found.

In the housekeeping department, among the maids for example, a very different situation appears. These workers are spread out all over the hospital. Even where two or more women are assigned to one floor, they usually divide the work, each one doing a number of rooms alone. In some instances a maid must go up or down a flight of stairs to find someone of her own group with whom to chat and exchange experiences.

One might suppose that where two women were working together, they would be more content than those working alone, if what has been said so far were true. This was not found to be the case. Several maids said stoutly that they preferred working by themselves. Further study brought out the fact that their objection to the pair relationship stemmed from their experience. Where no supervisor was close at hand to regulate such things, the more timid of two workers found herself

stuck with the larger share of the dirty work! In the laundry there are many jobs which are done by pairs. However, these aren't always the same two individuals who work together. There is some interchange among persons. Moreover, in all cases the rest of the work group, as well as the supervisor, were nearby and looking on, so that an aggressive individual would have a more difficult time in taking advantage of another and getting away with it. The maid, to sum it up, either works by herself or, when she has companionship, she may have to pay so high a price for it that it loses its attractiveness, whereas in the laundry the workers can enjoy fellowship and the group provides its own controls to prevent abuses.

Another example which seems to substantiate this theory of the importance of spatial considerations is the sewing or linen room. Sometimes this is officially a part of the housekeeping department, sometimes of the laundry. It was found to consist of one room and anywhere from two to twelve women were working within it, each at her own sewing machine. It looked like individualistic work, but observation quickly disclosed that these employees tended to do a lot of chattering back and forth, conferring on details of their work and comparing notes on life in general. In other words, the pattern of human relations resembled that of the laundry more than it did the housekeeping department, and here again one found employees of long standing. It is reasonable to suppose that the network of friendly associations helps to keep these women contented in their jobs by giving them the "feeling of belonging" that is so important to all of us.

Working Conditions

The linen department does "clean work" compared to that of many housekeeping employees who must mop floors and tidy bathrooms. It may be supposed that this also contributes to the stability of these workers. We have no doubt that this is true, but it is difficult to measure its effect. In the laundry working conditions are often far from ideal. Even those who work with the clean wash may do work of a boring, routine nature. In addition, uncovered presses may pour forth heat on a summer day and the dampness may become intense. Not all laundries were like that. We visited some which were as pleasant to work in as any other place in the hospital. The important point to note, it seemed to us, was that even where conditions were bad the workers would complain bitterly but they didn't quit. Housekeeping employees, on the other hand, seemed to be discouraged to the

point of quitting by even minor inconvenience. Our assumption therefore is that while employees very much appreciate management's consideration of their well being, they are not unreasonable about conditions which they believe are outside of management's control. Where other factors are favorable to their staying on the job, they will do so and will put up with considerable discomfort when they see it as inevitable.

Another factor which strikes one as possibly relevant is the presence of patients. Perhaps housekeeping employees dislike to work around sick people. While this also is true in some instances, many of these workers said they enjoyed being around the patients. They commonly reported that it worried them at first but in time they grew to like meeting all kinds of people and became interested in medical information. Some became proficient at picking up bits and scraps of knowledge which they used to advantage back in their own neighborhoods. This has been discussed in the chapter on nursing auxiliaries. As a factor in employment, it cannot be said that the presence of sickness is seen as a handicap insofar as most workers are concerned. Perhaps the conversations with patients even helped to keep housekeeping employees on the job to the extent that it assuaged their feelings of loneliness.

It might be said in passing that while the housekeeping employees had more direct contact with patients, both they and the laundry workers were aware of the underlying purpose of the hospital and it gave a meaningfulness to their labor. It was not unusual to hear consolation taken in the fact that one's efforts relieved to some extent the miseries of the "poor sick people upstairs."

Patterns of Supervision

The question of group leadership is a complicated one. Not all of its aspects can be discussed here, but one or two factors may be important to this analysis. In the laundry one hears these kinds of remarks:

I like it here because the bosses are so nice. Mr. X is a very kind man. He doesn't act uppity at all. He always stops and talks to everyone. Another thing, he lets you work about as you want to, so long as you keep up.

Our supervisor is a hard worker, you have to admire her for that. She never interferes with your work either

It is easy to spot shirkers in a department where all work together in one room. Everybody can see both what work remains to be done and how much each person is carrying of the total load. The supervision doesn't have to be obvious. A shirker would get into trouble not only with her supervisor but with her fellow workers as well. Therefore, the problem of disciplining the individual worker is that much simpler for the supervisor since she has the whole group with her. Similarly, the workers can see their supervisor throughout the day and become acquainted with her or him, as the case may be. The same network of relationships which binds them together will involve the supervisor too. This doesn't necessarily make her job easier, in the long run. In one respect it makes it much more difficult, for while she has their assistance in controlling individuals, she would find it extremely difficult to discipline the whole group if they united against her on any matter.

The supervisor's best help comes from the nature of the work flow and the visibility of the work to be done. For example, one explained:

You never have to tell them to work hard because they know as well as you do how many patients are in the house and how much work has to be done before they are finished for the day. They know what time remains to finish it in so they just work steadily and get through with it. They like to finish early enough to take it easy the last half hour or so. Sometimes they have to work overtime but they take that with pretty good grace. . . . What we do here, I give them time off on their short day and make up for any overtime during the week. They like that. . . .

This same supervisor commented later in the day, when she saw the press operators leaning against their machines and engaged in conversation:

I don't complain when the girls stop to rest like that. They're good girls and we don't have trouble with them. They take their work all from one basket and never argue about who does what.

It may be seen that where a group is united in spirit, the supervisor could afford to be lenient so long as she was able to get the work out within normal time limits. It might be said that in the laundry, the work sets its own pace. So much comes in during the day and so much must go out before nightfall. Within the limits of the day, however, a degree of control can be left up to the workers. If they want to work

hard during the morning in order to take it easy at the end of the afternoon, who would wish to complain?

In the housekeeping department, a different situation exists. Most of the employees work alone and their day's work is not so easily measured. If a cleaner cuts corners today, she can hope that nobody will notice it this time. It is only after a matter of weeks that a careful worker can see the results of her diligence and sometimes not then. There is a flat succession of days, each one like the others.

The patients are a complicating factor to the supervisor since a maid can always claim that the patient was too sick to be disturbed on a given day, hence that she was justified in doing a sketchy job, and it is difficult to prove otherwise. The patient's needs also make necessary the employment of night shifts and week-end auxiliaries, and these extra workers are a handy scapegoat for blame when things aren't well done. Bitter are the gripes about "Sunday help" and "that darned night shift." These extra workers have the task of swiftly tidying up a vacated room in order to prepare it for emergency use and they therefore have an excuse for cutting corners to gain time.

With her workers spread out in space, the housekeeping supervisor must spend a good bit of time just traveling from one person to another. The employees seldom see her busy working at recognizable tasks, hence they think of her more as a walker than as a hard worker like themselves. "All she ever does is walk around." They may think of her as a disciplinarian more than as a fellow human being, because that is the role they actually see her in most of the time. This makes it difficult for her to establish rapport.

Maids commonly state that they resent the sometimes necessarily close supervision, the finger run along the windowsill checking for dust. However, the other extreme is also painful to them. Some feel stranded and neglected, their hard work unrecognized, if nobody comes around to see how they are making out. They get the attitude, "What's the use, nobody appreciates what we do anyway."

A discussion of supervision would not be complete without mentioning the very obvious fact that it is easier on the nerves to have one boss than several. In the laundry usually one person is in charge of the whole department, with occasional "straw bosses" in charge of segments of the work such as the mangling or washing. This means that each worker is responsible to two individuals at most, and the duties between those two are plainly marked. In addition to authorities within the housekeeping department, a maid is frequently under the super-

vision of nurses who work on her floor, in particular the head nurse. She also may receive orders or direction from others such as painters, nurses' aides, and so forth, who also want to work in the rooms she works in and who may wish her to go away and return later at a time more convenient to them or the patient. If they ask her in the name of the patient, how can she refuse? The maid is never able to reverse the procedure and ask the nurse or painter to come back later. At most she can be stubborn about taking her time. It was only occasionally that complaints were made along these lines. Evidently most maids and other housekeeping employees adjust to the situation, but occasionally it did bother them. They would protest:

After all, a maid's work is important too. Why is it always me who has to come back?

The relationship between the maids and employees of other departments will be considered again when the topic of supervisor status is discussed.

Status Considerations

In one case known to us, a group of housekeeping employees did form a clique or cluster. These were night-shift workers whose task it was to take care of emergencies. Between calls they had a habit of sitting in the housekeeping office talking to one another to pass the time, and thus they came to build up a close relationship among themselves. Does it support our theory or injure it that these employees quit in a body? They decided to act concertedly to protest the fact that instead of upgrading one of their members, management had brought in a new supervisor from outside the hospital. In addition to being interested in this display of group-mindedness and its negative aspects, we were intrigued by the pronouncement these women made before quitting. They said that they didn't like the job anyway because nobody respected them! The nurses were high-hat, thought they were wonderful just because they had a white cap on their heads. Everybody looked down on them, including their immediate supervisors. Who would want to work under such circumstances?

If the laundry and housekeeping employees are compared, it will be seen that their relative job status isn't very different. The skilled workers have a certain prestige but the others are about on a level with one another. However, this difference occurs: the laundry workers are among their own kind whereas maids and cleaners are surrounded by

professional personnel. A laundry employee may not think about her status because nobody reminds her of it, but everything seems to conspire to remind the maid. Occasionally she will be a special "pet" of her floor, but more often she is not made to feel part of the gang at all but is merely tolerated as a necessary but low-caste appendage to a nursing floor. Accordingly one cannot be surprised at the frequently negative attitude which maids take toward nurses. Here, for example, is the way one maid spoke:

Oh, I get along fine with the nurses, they don't bother me none. I'm a Christian and I can take it in my stride. Now the other girls have trouble sometimes, but I just tell them they should pray for that person and keep right on going and after awhile they will come around. But some girls can't do that. They get defeated and quit. Some people just sort of get defeated.

When direct questions are put to them to find just what it is that is so discouraging, the complaints seem to turn into mist. Nurses are just "high-hat" or "uppity to us," or "they don't know we're alive." Doctors come in for similar criticism. As one maid put it:

It differs with different ones, of course. Some nurses are very nice to you and others aren't. Some of them wouldn't get friendly with you if they knew you for a million years. Same thing with doctors.

Now with me, I always make a point of speaking to them first. I always say, "Good morning, Doctor," and then they will say, "Oh, good morning." Some of the girls they can't do that. They want the other fellow to speak first and their feelings are hurt when people pass them by without even speaking, saying hello. I know, they talk to me about it. See, I'm one of the older girls around here and when they have a gripe they come down and tell me about it in the locker room.

It is difficult to know how one could best integrate a maid into a floor unit. One nurse wrote to us as follows:

No ward maid that I'm familiar with ever gets the kind of daily information she would have to have to do any planning of her work. Shouldn't she know who is scheduled for surgery, laboratory tests, special treatments, etc., in order to plan her daily work? Maybe such information would prevent her from mopping the wards during rest hours, which she may do as a last resort and of course at the expense of good patient care.

Whether the use of the team approach to nursing helps in this problem or not, we have not had opportunity to learn.

It may be seen how similar the maid's remarks about the doctors were to those of the maintenance man quoted in the chapter "Men at Work." The difference in the two situations lay in the fact that the maintenance men spend a good bit of time downstairs in their own workshops and can find fellowship there. The maid spends her time, so to speak, in alien territory and only sees her own kind at lunch hour or in the locker room.

We did not encounter any antinurse prejudice among laundry or linen room employees. Their only contacts came when nurses visited their department to check on some supply problem, and then the nurse was the one to feel strange. In one laundry an employee had the task of pushing a cart of fresh linens up to the nursing floors in the late afternoon to replenish linen closet stocks. This job was always given to the newest employee, we discovered. The others said that they didn't really object to doing this task but hated to miss out on what was going on in their own department! The new girl who had the job said it was the part of her work she liked least.

The role of the janitor is, of course, similar to that of the maid. When he makes friends with the people who work around him, it is usually at his own initiative rather than theirs. If he is a quiet person, he can be terribly isolated in the midst of a crowd. Janitors were discussed in greater detail in the chapter "Men at Work."

Exceptional Cases

Cases which did not fit the above analysis are especially rewarding to study. For example, there was the phenomenon of the "pet maid." In one hospital two maids had been employed for twelve years. One in particular had won a very special place for herself on a private floor by reason of her personality and willingness to serve. Patients who didn't know any of the nurses by name would enter the admissions office and ask to be placed on "Mrs. O'Brien's floor." This didn't please the nurses, but Mrs. O'Brien was delighted and told the interviewer that she loved her work so much she would work for nothing if she had to. Her reward came from the recognition she was receiving from grateful patients and from her own feelings of usefulness.

Another exception was found in a whole group of wall cleaners. These were women employed by the housekeeping department, and some of them had been in their jobs for as long as twenty-five years.

They had won a special niche for themselves; in fact, the tales told about them assumed the proportion of legends. One nurse told us smilingly that they would descend upon a room and completely take over. Anybody who didn't step aside was apt to get washed down along with the walls and furniture. They always worked as a team, either in fours or in eights. They talked to the interviewer without any apparent difficulty, but it was said that if anybody tried to give them orders, they pretended that they couldn't understand English. Management came to bow in acknowledgement of their professionalism and let them do things their own way.

When the interviewer went to talk with these employees they characteristically insisted on being interviewed as a group. Delighted to be a part of the study, they crowded around and everybody talked at once. They showed off the room they had just finished, with obvious pride in their careful workmanship, and told the interviewer that their walls were never streaked and that they never got themselves dirty either.

When they were asked whether the doctors or nurses gave them orders or suggestions, they shook their collective heads no. Then one spoke up and said in a kindly way that the nurses were nice and that they always tried to help the nurses out if they were asked "real nice." It was easy to see who was on top in this situation.

Perhaps a more notable exception, because it is more frequently found, is that of the maids who work in the nurses' residence. These people are just as spread out in space as are the ones who work in the hospital itself, and resemble housekeeping employees in their general background and work habits. However, since most of their work is done during the day when the nurses are either on the job or asleep, these maids have more freedom both to get together during the day and from interference from higher status persons. In other words, they have greater control over their immediate work environment. We found that the maids who worked in these residences had longer tenure than those who worked in the hospital.

We have been told about other hospitals where there was no difference between the stability of housekeeping and laundry workers. Investigation disclosed that these hospitals had very advanced personnel policies. For example, they had special meetings for housekeeping employees where the workers got together to exchange views, or they had "clinics" where problems were thrashed out. We shall discuss such features at greater length elsewhere. It may be noted that such devices

serve, among other things, to give a sense of group fellowship to employees who otherwise would not acquire a sense of belonging.

We noted that male employees in both housekeeping and laundry departments tended to have shorter terms of employment than the women, although the laundry workers were somewhat more steady. One exception to this was a laundry which had a male supervisor. He had a crew of twelve men and twenty-one women and his men, on the whole, were more stable than any we found elsewhere. In general it might be said that men who work in situations where they are surrounded with women are not so apt to become closely knit parts of the group as the women are. Their relationship is usually a simple joking one, whereas the women sometimes form deeper attachments among themselves. There are, of course, many more jobs available to the semiskilled and unskilled men, and this may place greater temptations in their way for transferring to higher-paying positions.

Disadvantages of Closely Knit Work Groups

While a sense of belonging may encourage the individual employee to stay in his job longer, it may also present problems to his supervisor. One overhears laundry heads muttering to themselves, "Think they own the place," and indeed they do. The long-term employee can be expected to develop a certain amount of possessiveness toward his job. He will also tend to band together with his fellows to control the environment around him. Any new employee will be sized up, measured according to his capacity to fit in with the old crowd, and if they reject him he hasn't a very good chance of surviving as a jobholder in that department. For this reason a sometimes remarkable homogeneity can be found within such departments. Not only will the workers freeze out individuals of other nationality or race, they will just as quickly turn on persons of a different age or educational background. This kind of tyranny of a majority over a minority must be guarded against in any stable social situation. It is no different in the laundry than in an exclusive neighborhood. The housekeeping department, on the other hand, by virtue of the fact that its turnover is high will have a much wider heterogeneity among its members. It is, of course, the right of management to decide how much variety it wants and can tolerate within the various departments. Most of the administrators and supervisors of our acquaintance seemed to aim toward a policy of moderation, compromising stability of the work force with

flexibility within the work group so that they, and not the rank and file, decided who should be hired.

Comparative Management Policies

Let us assume that their attitude is shared by others and that the question is posed, how can a department achieve stability without sacrificing flexibility? It is not within the limits of this study to give definitive answers to problems, but some observations may be made concerning possible alternatives.

Obviously there isn't much that can be done about spatial relationships. Maids will continue to have to do their work on nursing floors, for example, but some of the disadvantages of this dispersion can be minimized.

The worst situation known to us existed in a hospital where the housekeeping employees not only worked alone but were expected to eat alone, each in his or her little utility closet. If they were caught slipping down the back stairs to chat with one another, they were severely dealt with. It might be noted that the turnover here was four hundred per cent a year. This is an extreme case, of course, but it is worth mentioning that when people work alone they especially need opportunity to get together at meals and rest periods. This is particularly the case when the work they do is monotonous and unrewarding in itself. Then the element of fellowship becomes most important as a compensatory device. We were told that turnover dropped in one hospital when adequate locker facilities were provided for such employees, and one suspects that having a locker room meant increased interaction, a chance for friendly lingering and talking over the day's business.

We have already mentioned the possibility of group meetings for housekeeping and laundry employees. Some executive housekeepers thought that it was too risky to take a chance on that.

Why, the first thing you know, they would be telling you how to run things!

This is certainly a possibility. It would take courage to face a group which has low morale and present them with an opportunity to "gang up" on management. However, one hospital did take this chance and reports that it is working out constructively. The employees seem gratified with the new recognition they feel they are receiving, and have come up with intelligent suggestions about work routines. It is too early to know whether turnover will drop as a result of this new de-

velopment, but one might expect that it would encourage the building of group solidarity, as well as provide a natural contact between supervisors and workers. To this extent it would be an excellent counterforce to the situation on the floors where the supervisor is usually seen as a disciplinary agent. In the meeting she would have opportunity to appear as a team member, intent on furthering the good of the whole group.

We have not had opportunity to observe the results of training programs but persons who have seem to be highly in favor of them. They report that showing movies, holding workshops in which skills are developed, and clinics where workers themselves provide the suggestions for how to go about specific tasks, have provoked enthusiasm and interest in employees.

We heard in several places that laundry employees invented their own procedures for handling contaminated linens, for speeding the folding of certain garments, and so on. They found it possible to share suggestions and new ideas, and this would seem to increase the meaningfulness of the work for them. It is very rare indeed to hear of a housekeeping employee making constructive suggestion except in the case of clinics and other special arrangements devised specifically to encourage just this sort of thing. In other words, what might be called constructive or healthy communication upward has to be artificially stimulated when the work situation is such to make it difficult.

Supervision and Relations with Other Departments

A difficult problem has been left to the last. Hospital administrators have expressed concern on the appointment of housekeeping and laundry supervisors. Should they be upgraded members of the rank and file, or strangers brought in from outside who never did manual work in that particular kind of department? On the one hand, they felt that upgraded maids, for example, made sympathetic supervisors but tended to be too easy on employees. What was perhaps more serious a matter, they typically had difficulty in achieving a healthy relationship between their department and other ones. They lacked sufficient poise and stature to associate as equals with other department heads and therefore, when interdepartmental issues were at stake, their employees came out the worst. This is part of the problem, for example, between the maids and other nursing floor employees. The maid is, in at least some cases, just about defenseless in the face of an aggressive nurse. Where the maid has a capable supervisor, however,

she can get her protection against any injustice, real or supposed. The final chapter of this book relates how the number of committee systems has grown and the increased necessity for representatives of different occupational groups to meet if current problems are to be overcome. On the floor and in the committee room, each work group needs able defenders.

Ex-nurses, ex-office workers, and other people more accustomed to exercising authority have been used as heads of laundry and housekeeping staffs. They met some of the above problems successfully but were finding it difficult to command the allegiance of their own work force in some instances. In addition, their employment was taking away the incentive of employees to work hard, for what was the use if the good positions were closed to them anyway? We saw one effective compromise worked out where an intermediate level of supervisors were appointed who were upgraded rank and file workers. Their elevation was regarded as a reward for faithful service, and to our observation they were doing a good job both in maintaining efficiency and in gaining cheerful cooperation from the workers under them. We did not see sufficient examples of this to know whether this would work equally well elsewhere.

It is probably safe to say that hospitals quite generally were faced with acute laundry and housekeeping problems during and immediately after the war. Ancient machinery and techniques were not up to coping with the heavily increased demands made on them. Since then a good bit of thought and effort has gone into the improving of both tools and management methods. A tendency toward greater mechanization which probably stemmed from sheer efficiency needs has improved not only the employees' morale but also interdepartmental relationships since work gets done faster. In addition, and perhaps of major importance, better qualified supervisors are being both hired and created. The Executive Housekeepers Association and the various hospital associations have been encouraging the professionalization of such individuals by sponsoring institutes and workshops where their knowledge and skill is increased.

Summary

Housekeeping and laundry employees are similar in their social and economic backgrounds and in the status of their jobs. However, a wide difference is frequently found in their stability on the job. One factor which may influence this is the face-to-face relationships of the

laundry workers who do their tasks within a small geographical area. Housekeeping employees, on the other hand, are dispersed and work among higher status persons with resulting feelings of inferiority and loneliness. Another possible factor involved is the nature of the work flow. Where employees can help to regulate the speed and timing of their labor, they find more satisfaction in it than they do in situations where their work is controlled by outside forces. Groups of workers form "norms" or habits of thought concerning such things as the successful coping with a day's load, whatever it may be. They take pride in meeting agreed-upon deadlines, whereas the solitary worker may see an even succession of boring hours and days, all alike.

Where supervision is unobtrusive, it seems to be easier for the employee to accept. Each individual in the group is held in check by his fellows as well as by formal disciplinary arrangements. Such supervision and group controls are difficult to approximate where workers are spread out in space. The well-knit group, on the other hand, raises its own set of problems, since the group-will becomes a force in its own right.

Hospitals are becoming experimental in their approach to the problems of management in laundries and housekeeping departments. Here, as elsewhere in the hospital, new programs are being inaugurated for the training and advancement of both supervisors and workers.

PART FOUR

SOME HOSPITAL DEPARTMENTS IN ACTION

CHAPTER 14

THE ADMISSIONS OFFICE

ANYONE WHO HAS BEEN admitted to a hospital as a patient may think he knows well enough what the admissions office is like. However, no single patient can truly comprehend what it means when a succession of individuals, each one different from the next, pours through one office within a brief stretch of time. It is the pressure and the uneven tempo which gives this part of the hospital its distinctive flavor. Perhaps the following notes will help to convey something of this. They were taken during a Monday afternoon in one of our larger hospitals.

Sample Hour in Admissions Office

- 2:00 P.M. Observer arrives, finds two girls on duty. One girl answers phone while the other takes histories from incoming patients, but there is some overlap as the two girls struggle to help each other.
- 2:02 Miss A finishes phone call, tells observer of hectic morning spent reshuffling patients to make room for five emergencies admitted late last night. Interrupted by phone ringing.
- 2:03 Doctor's office calling for room reservation. Told first bed would be available in two weeks. Room reserved.
- 2:04 Miss B on phone talking to Medical Records Department. Asks for admitting diagnosis. Miss B is struggling to complete insurance forms for Blue Cross.
- 2:05 Negro workman comes in, has thick Southern accent. Tells Miss B his wife is in Ward H and is distressed by three deaths

occurring there in last two days, one in the next bed. "That ward just ain't the place for her, not for somebody with heart trouble. She shouldn't be having that trouble. My Blue Cross is supposed to get me a semiprivate bed for her." Miss B. takes down details, promises man kindly she will try to arrange for transfer but that space is short. He continues talking, repeats details over and over, is obviously very worried about his wife. Miss B has to break off conversation to answer phone. Man shuffles out of room, still talking dolefully to himself.

2:08 Miss A on phone saying, "Well, we wouldn't have anything for her today, Doctor. Could you call us back this evening in case anything opens up? Thank you."

2:11 Mexican comes into room, clutching his side. A young railroad doctor accompanies him. Miss B takes history, finds that man has just arrived in town, his relatives all live in Texas. He answers her questions with blank stare or mumbles confusedly. Doctor answers for him and observer is sure he is inventing the details. "Age?" "How old are you?" Man stares. Doctor says, "You were born in 1912, weren't you, Pietro?" Man nods and Miss B writes down 1912.

While she takes his history, three people enter room. One is a page from the outpatient department. The second is a young woman patient, and the third is her father. The outpatient department has already notified the admissions office that this emergency cancer case is to be admitted at once. They wait for Miss B's attention. The father never says a word, stands staring sadly at his daughter. The daughter keeps asking, "Will they operate on me right away? Well, will they operate tomorrow?" Miss B patiently replies that the doctor will tell her.

2:18 Interne enters. Tells girls that ambulance call was about a drunk whom he found lying in a gutter. Drunk claimed he had been hit by a car. Interne asked him, "Were you hit by a car?" "Yup." "Were you hit by a trolley car?" "Yup." "Was it an airplane that hit you?" "Yup." "You haven't been drinking have you?" "And how, Doc." The interne smiled and told the girls, "You can scratch that one off your list, he's sitting in the hoosegow with a bandaid across his nose."

2:20 Miss A on phone says, "You mean Vogeler didn't discharge that woman? Ye gods, and I told Mrs. So-and-So she could come in. Now what am I going to do?" Before she can take her hand off the phone, it rings again and she groans.

- 2:23 Phone call from student health office, reporting that nurse is on her way over as a patient and could she be placed in room 362? Miss A phones the floor to tell them that the student will be coming up shortly.
- 2:28 Miss B says on phone, "Well, all I can do is put her down on the emergency list and call you when a vacancy occurs, Doctor. Could she possibly wait two weeks for a semiprivate? All right then, we'll bring her in as soon as we can."
- 2:42 Miss A tells Miss B, "That woman is complaining again." Tells observer that they already transferred the woman once and now she is driving the nurses on the new floor to distraction. Miss A remarks, "I said to her, 'I should have left you over on Floor X,' and she said, 'Yes, I guess you should have, I hate it here.'"
- 2:48 Night shift clerk phones in to inquire how busy they were. Is told that it isn't too bad.
- 2:53 Miss B tackles the clerical work for the Blue Cross but is interrupted by another patient arriving. Takes history.
- 3:00 Phone rings, Miss A says, "Well, I'm sorry, Doctor, but the earliest date . . ."

All of the persons with whom the Admissions Office works want essentially the same thing, yet it is often a diplomatic feat to accommodate their respective needs and desires. Entitled to first consideration, of course, are the incoming patients. A new patient wants to find himself in friendly and competent hands. He needs to be made welcome and to be put to bed as promptly as possible. The second group whose needs must be met is the medical staff. Each doctor desires to see his patients admitted and placed in a situation where therapy is not interfered with by social or psychological discomforts. The third party is the hospital organization. Each new patient must be fitted into an ongoing system in a way which maximizes well-being of the whole.

Problems arise when the influx of patients is uneven or, as it is practically everywhere today, so heavy that the organization becomes swamped. Space, time, and personnel are relatively inflexible items. If patients come in a flood, they cannot be readily accommodated. If they all have influenza, the floors set up to care for respiratory diseases will soon be overflowing while others, for example obstetric wards, will be standing idle and so will obstetric nurses, who must be held in readiness for their own specialty. New patients require a good bit more attention than do those who have been in the hospital for some time.

There are many routine tests to be run, diagnoses must be made, and so on. Each nursing floor can adjust to only a limited number of newcomers at a time. The efficient allocation of patients to floors, therefore, can be of crucial importance. Chiefly, however, the problems of the Admissions Office center around the fact that the commodity handled is one in scarce supply, namely, hospital beds. It is inevitable that some heat will be engendered at a point where such an item is dispensed.

The Patients

A new patient must learn how to be a patient. He must adjust to a new environment, away from his normal activities and patterns of relationship. The Admissions Office is the first step of the way for him, and whether or not he will become a cooperative member of the hospital community may be sharply influenced here. This is where the pattern is first set. People react variously to new situations, of course. Some patients are belligerent because they are fearful. Others are irritable, childish. However, hospital personnel report that for the most part incoming patients tend to be passive. One told us, "We find people are nicer here, they aren't trying to put anything over on you." Another said, "They are funny, I don't know, there is a whipped air about them." A third, with perhaps deeper insight, commented, "They are like children, in need of emotional support." From the patient's point of view, the admissions clerk symbolizes the hospital. If she is warm, kind, if she goes about her duties with quiet self-assurance, he comes to feel that the hospital is a good place, a place of refuge. If he does not get this kind of treatment, he will see it as an additional threat to his security and go to his bed feeling hostile and on guard. He is, of course, already under the threat of his illness and the disruption of his normal activity.

Even the most conscientious clerk will sometimes fail the patient when the evening crush of work occurs.

An observer spent one evening just sitting in the waiting room to see life from the patient's point of view. Among the people waiting there were three elderly sisters. They were very neatly dressed and sat patiently as the moments ticked by. Nobody said what was wrong with the sick one, but she remarked that this was the third time within the last year that she had been here for surgery. She was obviously in pain, her eyes were clouded with it and from time to time she would press her handkerchief to her lips as if to keep from crying out. The other two wouldn't hear her pleas that they go find themselves something to eat.

They explained they came to the hospital right from the train, because the sister felt so ill. The only reason they were able to get a reservation at all, they said, was that the doctor had pleaded with the admissions office. The sisters would look up eagerly if any person came down in the elevator. They would say, "Do you suppose that's the patient leaving now? Will we get his bed?" Once a nurse approached the reception desk and one sister said, "Oh, this is it, I know it. Now we will get that room." As time passed, the sick one didn't say anything more, but sat pressing her handkerchief to her lips. None of them went to the desk to ask for help but followed each movement of the attendant with anxious eyes and with growing despair. Finally, after an hour of waiting, their turn came.

It is important that the admissions personnel know when to send a patient directly to bed, getting his history later or leaving it to nurses to acquire these details. Similarly, in planning for patient placement, they should be able to distinguish acute illnesses from chronic ones in order to give preference to the most desperately ill. This may call for a certain amount of familiarity with medical terms and facts which the new admissions clerk without adequate background may be slow to accumulate.

While patients are apt to be passive in this office, relatives of the patient are occasionally quite aggressive. They may need as much or even more psychological reassurance as the sick one. Admissions clerks will sometimes remark, "I don't blame them; I know how I would feel if it were my mother who was kept waiting." They understand and sympathize with the relatives, but that serves only partially to ease the situation. It doesn't produce enough beds to go around.

The situation may be eased somewhat by efforts to stagger the appointments of patients. The admissions office may telephone patients and ask that they come in at three-thirty instead of during the evening, for example. The difficulty is that patients due to go home may not leave by three-thirty. They may wait until a member of the family calls to escort them, and that is often after working hours. A bed is unavailable until after the floor personnel have time to clean the room and put it in order for the next patient.

The taking of a new patient's history can be time-consuming. If the admissions clerk is sympathetic, the patient may pour forth a long tale of woe, both personal and medical. It is an important part of her job to be tactful in such a situation, listening patiently when the flow of words cannot be stopped, and bringing it to a natural halt when that

is possible, by redirecting the patient's thoughts to the next piece of business. A depressed patient may hardly respond at all to her questions, or may respond so feebly that she must ask each one several times before getting a clear answer. In one instance, we observed such a patient greatly cheered when the employee said to her kindly, "Do stop by on your way home and let us hear how you like our hospital." Perhaps this was the first intimation the patient had that anybody expected her to recover sufficiently to go home again. At any rate, she beamed and walked out with a new vigor, evidently feeling that she left a friend behind her in the admissions office. It is spontaneous courtesies such as this which make the difference between a successful admissions person and a merely adequate one.

The administrator is the one to decide whether or not the admissions office is to concern itself with the patient's ability to pay. When this is left to the credit office, the admissions people need consider only the patient's medical needs and his preferences. There is always the possibility that they may inadvertently place him in a room beyond his financial means and have to transfer him later. On the other hand, if they must also take financial matters into consideration, their task becomes even more complex, and if they are required to dun the patient in advance for money, it becomes worse! Unfortunately hospitals with a largely transient clientele, such as may be found in rooming-house areas of a large city, find it necessary to protect their financial investment by some such technique. It is apparent, however, that a choice must be made. Either the admissions staff can make the patient feel welcome or they can confront him with a demand for money.

Another difficult problem concerning patients at admission time is that of screening. Probably every community has its share of known deadbeats, people who can afford to pay their bills but don't, and who prefer to convalesce in the hospital's most expensive room. There are also those patients for whom a given institution may not have adequate facilities, such as alcoholics, drug addicts, persons with suicidal tendencies. In our society, shame is still attached to such disabilities. Admission into a special institution devoted to their care therefore can be seen as a public announcement of deviance, and out of kindness to the patient or his family, a physician may try to get him into the general hospital under cover of some diagnosis such as "chronic headaches." The administrator may ask an experienced admissions person to advise him about cases which appear to be doubtful. Then there is the

rest of that sad parade of the unwanted: the old parent who is not sick but for whom the children just haven't room; the semi-invalid who may live for years but for whom there is no room in the local nursing home. Making decisions about the rejection of such persons is not easy.

There may be explicit or implicit rules regarding the admission and placement of members of minority groups. Some hospitals will profess to treat everyone alike, regardless of nationality, color, or creed. At the same time they may try to avoid "tensions" arising from divergent cultural patterns coming into conflict on nursing floors. Patterns of segregation differ and in some cases may truly be nonexistent, but we found a widespread belief that people who are alike should be placed together while the unlikes should be kept separated. This is the kind of thing which was prevalent:

ADMISSIONS CLERK: Oh, we have absolutely no discrimination here. It's against the law of the state, you know. We treat everybody who comes here alike.

INTERVIEWER: Doesn't that represent occasional difficulties?

CLERK: Well, yes, it does, but we just have to treat them all alike because that's the law. Of course, we have to use our judgment, you understand. We don't put them in just any semiprivate room. You have to exercise judgment. We had a case here a week or so ago that was really very difficult. I must admit this man did seem very well educated and well dressed. He insisted that he wanted a semiprivate room and we just didn't have one, and that was the honest truth, too. We just didn't. He said he was willing to wait in the waiting room and perhaps something would open up. After all, when they are willing to wait, what can we do? All we can do is tell them that there's a bed in a ward for them but if they wish to wait, we're willing to wait also and if anything comes up, we'll let them know. Well, this man waited two hours, and you could see that he really didn't feel very well and then, by golly, a room did open up. As it happened there were two beds in that room and both of the white men were going home. That makes it easier, you know. It's much better to put them in an empty room and then move a white person in later. That way you can ask the white person do they mind if they're in the room with a colored person, and if they want a semiprivate room very badly they will go along. That's what happened in this case. The next man who came in, I told him that there was a room open but there was a Negro in there, and do you know he accepted it! [Her face showed her surprise.] There was absolutely no trouble at all. I never heard one word about it.

Hospital policies tend to reflect the attitudes which are prevalent in the community from which the clientele comes. Since our study took place during a period of rapid social change, several of the hospitals we observed were in process of modifying their treatment of minority groups, and always it was in the direction of greater equality.

Doctors

The first thing which happens in the case of an ordinary admission is that the doctor or his office nurse will phone to place a room reservation for the patient. The doctor may be the patient's family physician or a specialist to whom the patient has been referred. The family doctor in particular will have some knowledge of the patient's financial circumstances, and his way of life. So long as the physicians cooperate in patient placement, and so long as there is space available in all types of accommodation, problems in this area can be minimal.

Ordinarily relations between doctors and admissions personnel are good. When bed space is scarce, the doctor stands to gain even more than usual by winning the good will of this office. Any admissions clerk with normal human feelings will do what she can for the patients. However, most of the time the incoming patients are strangers, and we seldom overexert ourselves for persons unknown to us. When an admissions clerk, exhausted after a busy day, tells you that she will "find a bed if she has to build it with her bare hands," there is usually a beloved physician somewhere in the background. That kind of service cannot be demanded, it must come voluntarily. What makes a clerk befriend a doctor? Partly it is the pleasant acquaintanceship that may have been built between them, but almost always it has a deeper source in the respect she holds for him. For example, after telling the interviewer that they absolutely did not discriminate among the doctors, but tried to serve them all equally, one admissions employee turned from the telephone and remarked with greatest sweetness,

That was Dr. Phillips. I'd do anything for him. He's just wonderful, so I always go out of my way to do him a favor.

Asked what he had done to win her approval, she explained:

He does a great deal of charity work around here. You'd never guess it either, he doesn't talk about it as some do. One of the nurses told me about a patient of his, a nineteen-year-old girl who was pregnant and was found to be dying of a brain tumor. She overheard him tell

the husband of this girl not to worry about the doctor bill. If he could pay it, all right, and if he couldn't that was all right too. That boy was only twenty-one and the girl could have lived for months. You can imagine how much money that fellow had. We're crazy about that doctor. Any one of us would work our fingers to the bone getting a bed for him.

Despite every effort of administrators and supervisors to censure discriminatory behavior, employees continue to be influenced to some extent by grapevine appraisals.

When beds are scarce doctors may begin to compete with one another, each striving to get his patients priority over the others, and if there is a lack of clear policy, trouble brews. The older doctor with the heavy patient load may claim special privilege on the grounds that he supplies the hospital with "business." He may also claim that his specialty deals with more acute illnesses than that of another physician, hence that his patients require more prompt hospitalization. The younger unspecialized doctor may be equally insistent that a strict policy of "first come, first served" be followed. Emergency cases, of course, are always entitled to priority, but any good admissions clerk knows that the claim of emergency can be exaggerated, and learns to discount the appeals of the doctor who abuses it.

One clerk recounted bitterly how she acquired her basic "education" in such things. A doctor had called up, when she was new at this work, and begged her to find a room for his patient. The man was in an awful state, he said, was "vomiting all over the doctor's office," and couldn't she please do something. The clerk took this very seriously and badgered everybody in the hospital until a space was found. Then she called the doctor's office back, only to have his secretary say blithely that the patient wasn't there just then, he and the doctor had gone out to have lunch together. They had figured that she wouldn't call them back for at least an hour.

A hospital cannot plan room reservations in advance to the same degree as a hotel. There are always patients who cannot be discharged on schedule because of a relapse, and others who insist on going home whether or not they are medically ready. It is this leeway between reasonable expectation and actuality which permits last-minute adjustments, and it is this leeway which each doctor may try to command for himself. Doctors are pretty much like anybody else in this respect, that when they become convinced a system is being followed and no favoritism shown, they tend to settle down to live within the rules

with average grace. The problem of admissions procedure is rooted in the fact that no hard and fast rules can be applied in all instances. Hospitals are places of recurrent crises, and all rules must be bent slightly at one time or another. The question is not whether to make exceptions, but how to make them; whether they shall be made by one person or by several, and whether they shall come capriciously or by some rule of thumb. It is inevitable that some competition will arise where demand outruns supply. The crux of the matter is who can best take that pressure and how it can be minimized.

The ability to distribute a scarce item means power as well as nervous strain. If the administrator chooses to keep that power himself, he will also get the headaches and time-consuming task of placating disputing parties. If he should choose to delegate it, he can expect to hear complaints coming up from below. It is not easy for an employee to deny the request of a doctor. His community prestige so far outranks her own that both of them feel uneasy in such a circumstance. Even when the administrator and the board of trustees stand firmly behind the employee and even when she is shrewd enough to offer the doctor every token of deference in her manner and attitude, there will remain a slight uneasiness. If her authority is not firmly backed, relationships will break down. The administrator can, of course, ease the situation by careful selection of personnel, but it is essential to note that regardless of individual differences, this kind of stress and strain is probably bound to occur at this particular point in any hospital.

There are pressures operating on the doctors, too. The patient and his needs may be such that the doctor very sincerely feels that it is imperative to have the individual hospitalized at once. In addition, the patient may be a close friend or relative. He may be an outstanding citizen and therefore important to the doctor for public relations reasons. Or he may have some rare disease or require a new treatment so that the doctor may feel that his professional growth is involved. For any of these reasons the doctor may bring considerable pressure to bear to get his patient special preference. Whether this will mean killing the admissions clerk with kindness, or browbeating her into submission, depends upon his idea of what will work to his and the patient's advantage.

In one hospital, tensions between the medical staff and the admissions office grew worse daily, and finally the administrator suggested that they all get together and talk it over. The head of the admissions office reported later that it was something to see. First, all the doctors

joined in scolding her and when she finally thought she couldn't take any more, they suddenly began to turn on each other. One man accused her of not finding rooms for his patients when they came in on Saturday to be prepared for a Monday morning operation. One of the others asked him,

Saturday? For a Monday operation? And who pays the bill for the week end? Do you think that is fair to the patient? Is it fair to the hospital?

Soon they were arguing with one another in a way which brought out issues the astonished admissions head wouldn't have dared to raise. As a result, she felt that they achieved considerable insight into the nature of her problems, and from then on, relationships improved.

The lack of space is the major problem which creates tension between the medical staff and this department. There are other minor ones. A doctor may complicate matters by expressing preference for some floors or nurses. He may request extra services from the admissions office such as delivering messages for him to other hospital departments. In particular, he may wish them to transmit medical orders to the nurses for the initial care of his patient. This is usually against hospital rules but it is a rule we saw broken many times by busy physicians and sympathetic clerks. How many extra chores the doctor can successfully pass on to the admissions staff depends upon their tolerance, his prestige in the hospital, and the extent of their friendship. The longer the staff have worked at this post, the greater the likelihood that they have been saddled with extra duties. This, of course, is not peculiar to admissions offices.

The Administrator

Since the hospital is not a world unto itself, the administrator must constantly keep in mind the public relations aspect of hospital care. He must face what others may wish to forget, that a hospital is not merely a curative institution but a social and, in a sense, a political one. The nonprofit, voluntary hospital typically gets only part of its funds from patient fees. Another portion of its income is donated by the more privileged portion of the community. A man who is entirely selfless in his giving may ask special consideration from the hospital when a member of his family is suddenly stricken ill. Members of the board of trustees may devote not only time and money but considerable

effort to making the hospital a place the community may be proud of. Is it too much to expect that they receive a bed promptly when they need one? And what of the sick doctor, or nurse, or faithful employee? Then there is the prominent citizen whose care will bring the hospital favorable recognition, and the city official who may later help to alleviate distressing neighborhood conditions or favorably modify welfare regulations. It is the administrator who must, sometimes against his own wishes, put aside personal considerations and base decisions on what will result in the greatest good of the greatest number. A consistent policy will help mitigate against excessive appeals for privilege but exceptions must occasionally be made.

One admissions employee told this story:

I receive a lot of interference. Mr. Kane [the administrator] doesn't know how much it upsets me. I can see his point too, he isn't always a free agent. But every once in a while he will phone and ask me what rooms are open today and I will tell him the four room numbers and that they have all been assigned. Then he says, "Well, I'm going to take 416 and give it to Mr. Able." Then he hangs up and there I am, left holding the bag again. What am I supposed to tell the patient when he comes in, after I have promised the room to him? What am I to tell his doctor? And you know, Mr. Able had just been talking to me a few minutes earlier and I told him there absolutely were no rooms open. Then he called Mr. Kane and right away he gets a room. What must he think? He thinks I'm a fool. How would you feel? It just upsets me so, you have no idea.

While this story was being told, the telephone rang, and after a moment's conversation the employee burst into spasms of helpless laughter. It was the head of admissions in a neighboring hospital who said she was so mad she could break somebody's leg. It seems that she had just assigned a room to one patient when the administrator came along and took it away to give to another one. She asked, "Do you have to put up with that?"

These two women, acquainted from other telephone conversations, discussed the possibility of getting together to talk over their common problems. It was their thought that if all the admissions personnel in one city could meet occasionally to discuss local conditions, they might all be better informed and therefore more able to give intelligent direction to patients when their own hospital was crammed to the doors, or when it was unable to offer the type of service being required.

We haven't heard whether this proposal was ever carried out into action.

Nursing Personnel

In order to plan intelligently for patient placement and to make prompt use of all available beds, the admissions office must know which patients are due to be discharged. It isn't always possible to predict when a discharge will be granted, of course, but the nurses usually can make a reasonable guess. Whether they will be found willing to confide that guess to admissions personnel, however, is another matter. In one hospital, the admissions office had the duty of phoning the nursing floors every afternoon to make a routine check. We asked whether the nurses could be believed, and the admissions girl laughed.

Certainly not. After all, they are human beings and they don't want any extra work if they can help it. The nurse in charge of the eighth floor south is a friend of mine and she always tells me the exact truth. On other floors they'll never admit when rooms will be opened up. It can be very embarrassing for us. Sometimes we advise the administrator that there isn't a room open in the house and he will say that he knows perfectly well that there are several. Then he calls the floors and sure enough, he finds two or three and it makes him furious. I've already called the floors back and asked them what the big idea was and they'll say, "But honestly the patient just this minute decided to go home!" What can you do?

We found that the floors where this problem was accentuated were those where nursing care involved major surgical cases, eye injuries, or acute medical illnesses. These patients can be richly satisfying to care for, but because they place heavy demands on the nurse's time and energy, there seems to be a sharp desire to recover psychologically after they leave. One nurse said that she thought it was the private duty nurses who felt this most strongly, although she felt that all nurses shared it somewhat. The private duty nurses, of course, very frequently get the more acute cases.

You get so you are completely identified with your patient and you hate to go on to the next one. You hear the private duty girls talk about it down in the locker room. You just keep putting off getting back on the register until you run out of cash and then you have to register again and at the end of the next case, it is the same story all over again.

Consequently, when a patient is due to be discharged, the instinct of the nurse apparently is to keep it quiet. She doesn't *want* another patient in that bed, not right away anyway.

This problem is especially trying when floors are already overcrowded or understaffed. A floor may come to feel it is being discriminated against and getting all the patients who are hard to deal with. This is most likely to occur when overflow surgical cases are sent to medical floors for want of other space. A surgical nurse cannot complain of receiving a surgical patient, but a medical nurse thinks she is being punished when she receives one. If he turns out to be a disagreeable person, she is sure of it. One admissions clerk said sharply,

Will you please find out what's the matter with those darned nurses? Did you hear what they did last night again? Miss Dean sent a patient over to Ward M in a wheelchair with a Gray Lady as escort, and do you know, they sent her right back to us! Said she didn't have the kind of disease they were set up for and that we should send her to Ward P. Now we had already checked with Ward P and they were completely filled up. Finally we got the administrator on the phone and he told us to ship the patient straight back to Ward M and to tell them that if they had any objections, to see him about them first thing in the morning. Those nurses on Ward M are always putting up arguments. They invariably ask what the patient's diagnosis is. Now what difference does that make? Miss Dean tells them, never mind about the diagnosis, she will send the patient's chart over with him, and then they get mad.

On another occasion, the admissions office was all sympathy for the beleaguered nurses. An irate patient had been making trouble for everybody and the admissions clerk remarked:

It is easy enough for us to criticize. We only have to put up with obstreperous patients for a few minutes, and can always work it out of our systems by griping to each other after the patient leaves the room. The poor nurses, they have to live with the patient, day in, day out.

An admissions employee may be annoyed when a nurse inquires what a patient's full name is, his diagnosis, his doctor. It may come at an inopportune time for the clerk, but such things can be of crucial importance to the nurse who has to plan for his care. When a series of conflicts occurs between this office and one of the nursing floors, it may be well to study the habitual contacts between the two sets of

employees to discover how such a distrustful feeling came to grow. It may be found that nurses and admissions people have virtually no contacts at all except in times of conflict. Here, as elsewhere in the hospital, it is sometimes necessary to set up channels of communication in order to encourage an orderly exchange of points of view.

Some hospitals employ nurses in the admissions office because they have found that this facilitates relationships. Others arrange to have the admissions employees visit the floors routinely, finding out directly which beds are empty and asking the nurses face to face which ones are soon to be emptied. When admissions personnel can stop upon occasion to chat with the nurses, they sometimes obtain a "feel" for the floor, learn how much stress and strain it is currently experiencing and how much more it can take. This takes an acquaintance with persons as well as a knowledge of room space.

Relationships within the Office

In the old days the typical hospital had an "Admissions Nurse." She did all of the work connected with incoming patients from the time of registration until he was tucked between sheets. In addition, she frequently handled credit matters, made out essential business forms, and kept track of medical statistics. She took care of all incoming patients regardless of whether they came in the front door on foot or the back door on a stretcher. In fact, a good bit of her time was spent beating a path between the front and back doors, and on elevators between her desk and the nursing floors. In her "spare time" she helped the business office with occasional chores, or acted as receptionist to visitors. Occasionally some of the work was done by nurses on the floors who took the patient's history and then routed it back downstairs, where the admissions clerk rewrote it with suitable carbon copies.

In the smaller hospital, this job description may still hold. In the larger and busier ones, however, a division of labor has generally occurred. One employee may act as receptionist, another as placement secretary, a third as historian. There may be a general reception desk on the first floor which handles all incoming traffic and is responsible to the business office, while other floors have their own receptionist who is responsible to the head nurse. Credit matters may be routed entirely through the business office while medical statistics are attended to in the medical records room.

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often occurs more or less spontaneously, with nobody actually sitting down to think the thing through from a logical basis. While efficiency may be increased, patient care may suffer. For example, it is generally held that the fewer persons a new patient must meet, the easier it will be for him to adjust. Certainly the old feeling of intimate, individual care is lost when no one employee is with a patient long enough to gain his full confidence.

In view of the increased work flow, a return to older, simpler forms is probably impossible, even if it were seen as desirable. Actually present circumstances have much to recommend them too. For example, the newer forms for duplicating patient histories as they are being written means greater efficiency and hence less tension, in all departments where copies of these histories are used. This includes not only the nursing floor but the business offices, medical records room, and laboratories.

Present difficulties are not impossible to overcome. For example, one problem is that each little cluster of workers may become convinced that its work is most basic and that it is being hampered by lack of cooperation on the part of others. For example, the people working within the admissions office may complain that they no sooner get a patient soothed and put into a good frame of mind than their work is undone by inept escorts who take him to his floor. Escorts will rejoin that by the time they get the patient he is already weary and querulous from undue delays in the admissions office. It is necessary occasionally to refresh the perspective of everyone by providing opportunity for each to comprehend, and if possible to experience, something of the function of the rest, if the patients are to receive uniformly excellent care.

Another influence on relationships, and a very important one too, is that of work space. Overcrowded conditions are vexing enough anywhere but the need for tranquillity in this place where patients receive their first impressions of the hospital is obvious. One admissions staff was experiencing acute distress:

I can't make them understand what the problem is. Look, my office is right next to the credit office. When I interview people they can hear the people next door trying to dun somebody out of their money. They will say, "Well, can you pay three dollars a week? Can you pay two dollars?" My patients are apprehensive enough already and when they overhear all that financial detail, it frightens them. You can see for yourself how small this office is. While somebody is trying to take a

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history, I'm trying to talk on the phone and the doctors come in and out—it is enough to drive you mad. How can we make the patients feel relaxed and at ease in such a situation?

Obviously all hospitals have many demands upon their space these days and the needs of the admissions office must be considered in the light of total circumstances. It is probably safe to state, however, that the quieter and more cheerful this office is kept, the better human relations will be throughout the hospital. It is a key post.

Conclusions

It may be seen, from all that has been written above, that admissions work can offer a rich personal experience to hospital employees. It has both paper work and human relations functions. It has drama and intensity. What is more important, it is so obviously important to the human beings who come there for service that the employee can feel his life counts for something when his work is well done. On the other hand, this work can be exasperating too, and when tensions mount the employee may well envy someone who works in a quiet nook in the hospital basement with nothing but test tubes to worry about. The ragged tempo of the work is one of its major problems. It is difficult to space the work, patients seem to come in droves or not at all, and hospital authorities always seem to look in the door at the wrong time, either when everything is deadily quiet and the employees are caught relaxing between rushes, or else when the place is a bedlam.

This work calls for exceptionally well-adjusted personnel. Like hostesses everywhere, they are expected to be gracious and charming as well as intelligent. Ideally the admissions person should know the community as well as the hospital. She should have a mental picture of all of the hospital's rooms in order to fit the patients into them intelligently. She should know at least the supervisory personnel on each floor, as well as the doctors and their preferences. She must be adept in human relations as well as efficient in business procedures.

Obviously nobody can meet all of these requirements equally well. The problem of the administrator is to decide what the most important criteria are and then to select his personnel accordingly, helping them to grow in other respects until they achieve the proportions which their work requires. Meanwhile, they will stand in need of his constant support, his sense of humor, and his good will.

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AN ACQUAINTANCESHIP with hospitals soon discloses the wide variety of circumstances which exist among nursing departments. The obstetric nurse and the orthopedic nurse do very different things, for example, and when they talk about their work they express different kinds of satisfaction. The physical and psychological needs of their patients are markedly dissimilar. Similarly supervisory techniques and work organization in use on one floor sometimes were found unsuited to another. We shall therefore not attempt to discuss "nursing" or "nursing floors" as if all were alike, but shall examine several types of nursing service and present some of the contrasts among them.

The obstetric department has been singled out for fullest treatment for several reasons. This department is especially important in shaping hospital-community relations, for in America today virtually all classes of people come to the hospital for childbirth. In addition, the obstetric department reflects many features which are pertinent to all hospital floors but which are seen most clearly here. There are several subdivisions to obstetric work, and the contrasts among them help to highlight the variety of situations to be found in nursing. We shall therefore discuss and contrast the work of the nursing staff in the prenatal or labor rooms, the delivery rooms, postnatal or maternal care, and the nurseries.

In all six of the hospitals studied, the obstetric department was found to have the highest morale. Its relative cheerfulness was quite apparent to the employees, and the nurses had a ready explanation

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for it. Elsewhere in the hospital, they reasoned, the ultimate goal of the work was primarily a negative one, the combating of destructive forces. On this floor it was positive and creative. The outcome of the work was almost always successful, thanks to the magnificent strides in medical and nursing sciences, yet the possibility of tragedy was still present so that each worker could feel that his or her contribution was a vital one. One supervisor modestly gave entire credit for the high morale of her department to the basic situation:

I think it has a lot to do with the patients. They are young and healthy, eagerly looking forward to life. It is a happy floor to work on for that reason. The quick turnover of patients is easy on the nerves too. We have fewer doctors to deal with than on other floors, and we seem to get along unusually well with them. Another thing is the students; you can't help but feel differently about them on this floor. What you have to say to them really goes across because they are eager to learn.

When the various subsections of the department were studied, however, it could be seen that relative job satisfaction varied considerably among them.

The Labor Rooms

Our observations were made in hospitals where obstetrics work was just one of the many types of service being rendered. It was not considered a postgraduate specialty, although one hospital did employ some nurses with specialized training. We observed no cases of "natural childbirth," neither did we see any examples of the "rooming-in system." In other words, our observations were probably run-of-the-mill and representative of the normal situation in most parts of the nation.

In these hospitals, for the mother labor was a difficult time of waiting. In some cases each woman in labor had her own small room, a cubicle virtually unadorned with only a bed and chair in it, possibly a crucifix or single picture on the wall. In others there were three or four beds, but even here the patients could be regarded as isolated individuals, each lost in her own immediate needs. For some patients this was their first hospital experience. Others had had preparation in prenatal clinics or classes and these women seemed to have an easier time in labor, according to their nurses.

Dr. Woodruff is wonderful. He talks to his patients ahead of time so they know what to expect. He tells them that there will be a certain

amount of pain and explains why it is so and how it can be minimized. They come very well prepared psychologically and you'd be surprised the difference it makes. They have easy deliveries and make us very little trouble. Now, some of the other doctors don't give their mothers any preparation at all and their patients scream and carry on. Sometimes it takes a whole crew of us to hold one patient down. All they want to do is climb up the walls and it is all fear.

Although an occasional nurse would say that the psychological preparation didn't make this much difference, most nurses agreed. Women facing their first childbirth experienced more difficulty than others, and this appeared to be due not only to the greater physical problem but to lack of knowledge and psychological preparation. In one case a new mother apologized to us for having screamed in labor and explained that it had been more fright than pain. Her "bag of waters" broke, she said, and she thought she faced permanent invalidism as a result. It wasn't until the next day that she discovered this was a normal occurrence, and it was the other mothers on the ward who told her this, not the nurses. It may be seen that where there is a wide variation among patients, with respect to their knowledge and expectations, the nurses would be at a disadvantage. They wouldn't know what the individual needs of each mother were unless there was time for extensive conversation, and time is often in short supply.

A variety of attitudes was found among the nurses toward their patients in labor. A few nurses found this type of work very satisfying. They seemed to find a good deal to do for the patient to put her at ease and to give her encouragement. Other nurses assured us solemnly that there was nothing they could do except to administer medications. Evidently the psychological aspects of patient care had not been stressed in their training. One graduate said to us in all seriousness:

There just isn't a thing you can do for them. In the surgical ward you can at least give them psychological care. You could talk to them and that seemed to give them courage and you felt that you were helping them somehow, but up here you can't do a thing.

We observed this nurse providing conscientious physical care to her mothers but noted that she had almost nothing to say to them. It is not surprising that she disliked this type of work.

Another nurse on this same floor was quietly going about her work in a way which demonstrated that something could be done to ease the strain of labor. For example, one patient summoned her and said anxiously that her labor pains were coming every four minutes and she found that she couldn't cry out. Although her husband was sitting beside her, she was afraid that she couldn't summon help when the time came for her to go to the delivery room. The nurse talked to her in soothing tones, saying that the baby couldn't be expected for some time. She gave the patient her watch and suggested she time her pains more precisely and note that they were coming more frequently as time passed. She then assigned a student to sit by the patient to give the husband an interlude of rest. The patient relaxed and later was seen resting quietly and smiling.

Another frightened patient told this nurse that she still felt pain despite the drug that she had received. The nurse explained that this drug wasn't given to stop the pain but to dilate the birth passage, and that pains were an important part of a normal delivery. This mother also visibly relaxed. The nurse, upon leaving the room, told us that almost all mothers would "try to help you" if you explained to them what was to be expected, and that they seemed relieved when they realized the nurse knew what she was doing.

To this nurse, labor work was fascinating. Many others expressed distaste for it and one wondered whether it was because they did not perceive the possibilities it offered.

In one hospital the students were being assigned to the labor rooms to sit with semiconscious patients. This particular hospital used heavy sedation and the students were bored and anxious too. There was little opportunity for them to observe a more competent person at work, for usually there was only one person assigned to the labor room at any time. Our interviews with these students were replete with this sort of comment:

The thing is, there isn't anybody to turn to. The delivery room isn't nearly so scary because you at least know that a lot of other people are around and you know what to do, what's expected of you. Here all you can do is sit and stare.

One of their worries was that a mother would deliver before they succeeded in getting her into the delivery room. This is considered a blot on the nurse's record, the implication being that she wasn't attending to her duty.

In hospitals where closer supervision was given to students, there was much less anxiety being expressed. The permanent floor staff testified that everybody benefited from the presence of a clinical instructor because the students were so much more calm, having someone to turn to with their questions. Even in these cases, however, it was unusual for a student to express preference for this work.

This is a rather lonely kind of duty, as well as a predominantly dull one, for most nurses. Not even the doctors come around very often. Unless there is reason to expect a difficult delivery, the doctor for the most part will keep in touch with the labor room by telephone. In this respect it contrasts sharply with the delivery room where nurses and doctors work in close cooperation. A few nurses complained, saying "The doctors push everything off on us," or "We do everything but deliver the baby for them and sometimes that too, and they get the money." Others looked for the good aspects.

Nurses have more opportunity to use judgment here than on most floors, maybe that is why the nurses and doctors get along so well. They are very dependent on us, particularly in the labor room. The doctor hasn't got time to spend at the patient's side so he has to take our word for things.

One visitor who was generally made welcome to this section of the obstetric department was the expectant father. The nurses reported that it soothed the patient to have her husband by her side. The men seemed shy in the presence of birth, and would sit quietly and hold the patient's hand and have little to say to anyone else. On the other hand, the mother of the patient was often regarded as a very trying visitor. One nurse said vehemently:

I often wish I could just draw a tight rope across that elevator door and not let any mothers pass at all.

The mothers it seemed, were inclined to be outraged to see their daughters suffering pain and demanded that the nurses "do something about it."

Absent relatives and friends of the patient still influenced her behavior in the labor room insofar as they had helped shape her expectations and attitudes. Psychological studies of reactions to pain seem to prove that there is no discernible difference in the threshold of pain according to cultural groups.¹ However, nurses observe dif-

¹ James D. Hardy, Harold G. Wolff, and Helen Goodell. *Pain Sensations and Reactions*. Baltimore: Williams and Wilkins Company, 1952.

ferently and sociological studies would appear to indicate that the *response* to pain does differ, if the actual experience does not.² In other words, while two persons may feel the same hurt, one believes that the appropriate things to do is to yell, while the other may believe with equal firmness that it is proper *not* to yell. The difference in attitude can make itself felt in the labor room. One nurse spoke of her embarrassment when her own sister-in-law, a Norwegian girl, gave birth precipitately. She hadn't wanted to "bother" the nurses and doctors by complaining when her pains became worse. In another case a young Italian girl explained why she had screamed so incessantly the day before when she was in labor. She said it was good for the baby when the mother screamed, it made delivery easier. Cultural differences are becoming less extreme, the older nurses assured us, but it still remains part of the nurses' task, particularly in city hospitals where there are many kinds of patients, to understand the attitudes of various groups toward pain and to determine what the scream, or the sternly bitten lip, might signify.

The vast majority of patients whom we observed in the labor room seemed to follow a routine and predictable course, however distressing it might sometimes have been for the mothers. In the few instances where a woman was seriously ill or threatened with an abnormal delivery, the interest and the attention of the entire staff was commanded by the very rarity of the event. To our observation such patients received devoted care.

Summary of Labor Room Observations

Work in this part of the obstetric department calls for considerable knowledge and skill on the part of the nurse. We saw excellent care given but were not always convinced that the psychological aspects were fully appreciated by all of the nurses as an important part of their task.

The patient in labor was a woman in pain. Her needs called forth pity and fear, particularly on the part of students. This was especially the case when the patient was having her first child and was therefore in greatest need of reassurance.

Since much of the work was routine, it was often assigned to individuals with limited training. This included student nurses, the newest graduate on the floor, and even upon occasion nurses' aides. It

² Mark Zborowski, "Cultural Components in Response to Pain," *The Journal of Social Issues*, Vol. VIII, No. 4, 1952.

was lonely work, with limited opportunity for interaction between the nurse and other nursing staff personnel, except when a clinical instructor was present to supervise the students. Where the nurse worked in isolation, there was little she could do to allay her own anxiety or to relieve her boredom.

When competent supervision was available, morale among the nurses in this section of the obstetric floor was higher than otherwise, but in general we found little enthusiasm for this type of work.

Delivery Room

Ordinarily a job under rigid hierarchical control which involved hard, sometimes very dirty work and considerable psychological strain would be regarded by the average American as undesirable. Yet in the operating and delivery rooms, jobs which certainly fit this description have exceptionally high status. More people spoke of enthusiasm about delivery room duty than any other aspect of nursing care. The work is clearly meaningful, but this cannot be the sole explanation for the high esteem in which it is held. Labor room work is also meaningful and just as important to the patient. A comparison of these two parts of the obstetrics department should throw light on hospital occupations and human motivation.

In the delivery room there are many symbols to induce a feeling of importance—the presence of intensively trained professional personnel, a glittering array of expensive and sometimes intricate instruments, a spotless room and immaculate furnishings, an atmosphere of hushed expectancy, and ritualized activities which are learned with difficulty but which confer a glow of satisfaction as precision and competence increase. Here a group of people cooperate closely in a highly specialized activity. Their coordination is hard-won but its rewards are great. The outcome of their labors is usually successful and the pride in the new baby, and the mother well started on her way to caring for it, is shared by everyone involved. The satisfaction felt by each individual in the work team is shared and hence supported by that of all other members of the group. The birth of the baby, it might be said, is the payoff. All the hard work seems recompensed.

It was not unusual to find hospital employees taking pride in their association with the doctors. Delivery room nurses were among those who mentioned this as a source of satisfaction.

You get to know the doctors much better here than you do downstairs. Down there you go in and scrub for a doctor and as soon as

the operation is over, you wash your hands and go and scrub for another one. You never get to know any of them very well, whereas in the maternity work you're almost forced to become well acquainted from the nature of the work . . .

Another thing on this floor, the internes and residents are always hanging around waiting for deliveries, so they are really a part of the floor, you might say. We have a lot of nice fellows right now and we have a good time. Of course the tempo is ragged here, you have more ups and downs. You can be terribly busy one day flying around like crazy, but the next day it's quiet and you can rest up a little. There is always time for socializing in between rushes.

All the nurses seemed to agree that "these men are easy to get along with, not like those downstairs." One obstetrician said:

There is a special type which goes into obstetrics. In fact I can almost pick them out from an incoming class of internes. It is usually the big, good-natured genial kind of person who goes into obstetrics because it is fundamentally happy work. You don't have the great decisions to make between life and death; for the most part your people get along all right. The incidence of the death of mother or baby is extremely low.

He said that he had himself been undecided on a specialty until his internship, but had a happy time on the maternity floors where everyone was congenial, and he just stayed on. Other doctors spoke of the pleasant combination of surgical and medical skills called for.

Skill and patience are tested in the delivery room and those who lack them are weeded out. The demands in tactfully handling patients and in getting along with the nursing staff tend to discourage those weak in social skills. Waiting around for deliveries is a test in itself. To specialize in obstetrics, then, a man must pass through a variety of situations successfully.

In the smaller towns and hospitals, a good bit of the obstetric work is done by general practitioners. This means that a broader variety of men are involved and their range of skills also tends to be greater than in the city institution, where a closed staff makes it easier to maintain rigid standards. The nurses were strong in the opinion that it was easier on them to work in a teaching hospital with a closed staff. The presence of internes and residents relieved them of much responsibility, for example in determining when to call the attending physician or to take the mother to the delivery room. In addition, the

resident was in a position to suggest consultation if the attending doctor seemed to be having difficulty. Nurses and internes alike testified that the "hardest thing in the world" is to have to stand by and watch a clumsy delivery. One nurse who had worked in small, open-staff hospitals said:

There's the biggest difference in the world among doctors. When a bad one comes in, you just have to stand by and grit your teeth to keep from saying anything. You're just praying that nothing complicated comes up. Of course if the department head is around, she can suggest a consultation, but otherwise all you can do is to keep your fingers crossed and pray.

In this hospital emotional tensions ran high because the competence of one or two doctors was questioned:

We always breathe a sigh of relief when we see a competent man come into the delivery room, especially when it is a difficult case. Some of these fellows just haven't had enough experience and don't take child-birth seriously. It would break your heart to see some of the mothers being torn. Even the ones with lesser tears may spend years of misery because a careless doctor doesn't sew them up right. Now that case you saw yesterday was different. I was able to tell that mother with a clear conscience that her doctor was one of the best in the country and that if anybody could have saved that child, he would have done so. It makes you feel awfully good to be able to tell them that. You wouldn't be able to say it for all of them. The same thing could be said with regard to the nursery. It relieves the nurse to know that a good doctor is in charge, especially if the infant is delicate.

This discussion touches on a most sensitive area. Grave problems are encountered when one occupational group sits in judgment on a member of another. Gross injustice may be done. Although nurses are strictly trained not to show preference among physicians, no one can enjoin them from forming opinions. The patient's attitude toward his hospital experience is very greatly influenced by his relationship with his doctor, and if the doctor fails his patient, he lets the nursing staff down as well. When a nurse thinks she sees professional incompetence, she may have a hard time hiding her feelings. The doctor is permitted to reprimand a nurse for what he regards as an error or may report her to her superiors and thus unburden his mind. The nurse usually has no recourse except to explode in private to other nurses. This is likely to have the harmful effect of developing and

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hardening group attitudes toward various doctors. In one hospital, for example, the nurses told us:

All the nurses here know who the good men are and who the poor ones are.

They were putting their heads together and pooling their resentment, and their attitude showed in their cold faces and short answers. It's no wonder that medical students tell one another it doesn't pay to get on the wrong side of the nurses.

Such judgmental attitudes seemed to us more likely to occur where extremes of competence existed side by side and could be observed by the nurses. Failure of the medical staff to discipline its own members also seemed to encourage this development.

We have discussed this problem at length in order to emphasize the interrelatedness of hospital groups and activities. When the medical staff is well organized and effective in its controls, the reputation it wins for itself has very direct influence on the behavior and morale of the nursing floors. In the same way, efforts of trustees and hospital administrators to bring about improved medical practices have an indirect bearing on human relationships all through the hospital. A department such as obstetrics, where cooperation among groups is especially close, will inevitably mirror not only its own internal pattern of human relations but over-all hospital policy and organization as well.

Another problem which runs throughout the hospital but which is seen most visibly in the obstetric department is that of ethical values. Contrary to what one might expect, we did not find problems around such relatively simple matters as abortion or other injury to healthy tissues. Hospitals have firmly established policies about such things, and, furthermore, the average doctor and nurse have a strong repugnance to unnecessary tissue damage. The troublesome problems arose where policies were not clear or where moral issues were in dispute. For example, relationships in one hospital were complicated because some doctors felt that Caesarian section was not morally justified except where normal childbirth was impossible, while others felt that the mother had the right to choice. In a hospital that had a clear firmly enforced policy in regard to tubal ligations, no problems arose, but where there were differences of opinion and no established policy, tension was found. The fact that there are sharp differences of opinion in the community at large about many of the problems in the obstetrical department makes their resolution more difficult in the hospital.

After saying that delivery work is generally satisfying, we seem to have given examples only of the hardships. To correct this impression, it might be well to describe a Caesarian delivery where everything went normally.

This operation was scheduled for 10:30 but didn't get under way until 11:00, while everyone waited for the senior anesthetist, who was busy in the main operating room. By the time it began, there were three doctors in the room: the surgeon, an assistant surgeon, and the anesthetist. In addition there were a variety of nurses. One graduate was scrubbing [working with the doctor within the surgical area] and had a student nurse helping her. Another graduate was circulating [keeping track of supplies, lights, etc.]. A third graduate supervised the care of the baby after the birth. There were three students who were observing, one of them for the first time. The other two kept whispering to her, "How do you feel?" and she kept replying with growing irritation, "I feel all right, for heaven's sake."

The anesthetist gave the patient a spinal injection. To do this the nurses had to curl her up like a baby caterpillar, to permit entrance of the needles. The surgeon asked to see the CBC [record of the blood count] and asked that the blood pressure be taken again. It was down to 50 and the operation could not proceed. A blood transfusion was given which sent her blood pressure back up to 128 and it was decided to go ahead. The surgeon was the one who decided.

The patient, a very tiny redhead, was restless and from time to time would call out, "Dan, Dan." Between periods of unconsciousness she would talk to her anesthetist, asking was the baby born yet. The other doctors did not speak to her but once she heard them talking to each other and asked what they were saying. The anesthetist said, kidding, "Oh, that's just Dr. Whelan, don't pay any attention to him, he just likes to talk." The surgeon laughed, commented, "That's right, build up my reputation for me."

The room temperature was 82° at the start of the operation and shortly went up to 86°. The surgeon told a student to stick close by him with a damp towel for his head. He was already perspiring and of course this endangered the surgical area. This student got a bottle of sterile water and poured some out on a towel. Immediately a graduate stepped over to her, whispered, "You've unsterilized it by touching the cap that way. Go next door and get another bottle." Without a word the student went next door taking the contaminated bottle with her and returning with a fresh one. She did not make that mistake again.

Meanwhile the surgeon was working. His assistant held back muscle

tissue with retractors and occasionally held up a piece to make it easier for the surgeon to slip the knife under it. Some of the tissues seemed to be paper-thin, yet the knife never seemed to cut deeper than it should. In this meticulous fashion, layer after layer of muscle and tissue were opened. The assistant helped to tie off "bleeders" as blood vessels were severed, but it was a remarkably bloodless operation.

During the early stages, only the two doctors spoke and usually to each other. When the surgeon addressed the nurse he would say, "Scissors please," "Knife please." His voice was low and pleasant but there was tension in the air. At one point, the baby was kicking and the mother's stomach was pushed out at a funny angle. The doctor motioned to it with his knife, and the nurses laughed.

As the climax approached, a student whispered to me that I would see water gush up and that everything would start happening very fast. This is just what happened. The doctor asked a student to have the suction machine ready and she pulled it into place. As the last cut was made, embryonic fluid spurted into the air, and with it a baby's hand stuck out. It was a little bit of a fist and it waved around bringing squeals of delight from the student nurses, and even the doctors smiled and joined in the general excitement. The suction machine quickly reduced the water, the doctor reached in and, turning the baby around, pulled it out head first. He had to tug to get its hips loose from the small opening. As it came out, the doctor laughed and said ruefully, "I lose my bet, it's a girl." At that point the tension relaxed completely, everyone laughed, the nurses exclaimed with delight over the beautifully formed infant. From then on, their attention was centered around the baby. The doctor squeezed the last bit of nourishment for it out of the mother's cord, cut the cord and handed the child to the graduate nurse. She carried it at once to the incubator, where, surrounded by students, the nurse used another suction machine to clear out its throat. Already the body of this infant was nice and pink in color and it was crying and squirming around and sucking its fist. In short order it was being pushed proudly down the hall toward the nursery.

After this crowd of students, nurses, and baby had left, the atmosphere seemed to lighten and people began to talk to each other with ease. The doctor's conversation included the graduate nurses but did not include the one student nurse left in the room, who was assisting with the scrubbing. The surgeon remarked that the needle he was using was poor. The woman had had Caesarians before and there was scar tissue to go through. The doctors commented on the work of the previous surgeon. The present one worked swiftly, carefully stitching the woman back together again. He had about seven or eight layers to do. The final layer was of skin and this was fastened with a row of clamps.

Then the doctor and anesthetist again discussed procedure. The surgeon told the anesthetist what to write down on the patient's chart. He asked, "Did you give her anything to eat?" The anesthetist said no, that he had ordered saline solution but hadn't administered it yet but perhaps she should have it now. The surgeon agreed. The anesthetist then asked, "Demoral?" [a sedative] and the surgeon said, "Yeah, let's give her one shot and write down diet as tolerated. I guess that covers it, doesn't it?" As he talked, he was stripping off his gloves and a nurse helped him out of his gown. He was carefully backed away from the surgical area. Then he looked around at the group, smiled and said, "Well that's all, folks, thank you very much." The doctors left, talking to one another. The anesthetist and the nurses helped one another to prepare the patient for her return to her room, and the student began cleaning up the mess.

Summary of Delivery Room Observations

Though the patient in the delivery room may be only semiconscious, her needs dictate all the activities which occur. However, the course of delivery is usually more predictable than that of a surgical operation, and the work of the team proceeds most of the time in a highly scheduled way with only very passive direction from the patient. The fact that the situation is so highly organized means that each member of the team knows what is expected of him and successful coordination results in both a high level of efficiency and considerable satisfaction to all concerned, especially since the result, the healthy mother and baby, are a cause for universal pride. The work is laborious and often messy, but is surrounded by symbols of importance and dignity and has high status.

Ethical values are prominent in this department but usually do not cause complication because hospital policy in regard to most issues is clear and well accepted. The tensions which do arise come over ethical problems in which there is no clear consensus. Gross incompetence, also fortunately rare, causes mental anguish when it occurs. Ordinarily there is a closeness and warmth in the relationship between doctors and nurses which both groups appear to relish. The extremes between periods of stress and periods of waiting appear to cement relationships. The first provides an opportunity to exhibit technical proficiency and the latter social adaptability. Delivery room work is a recognized specialty for both doctors and nurses and thus is accorded high status.

Post-Partum Care

Moving from the drama and excitement of the delivery room back to the nursing floor, we find ourselves in a very different atmosphere. The baby born, the mother is relieved and at peace again. Until recently a newly delivered mother was regarded as an ill person. Her diet was restricted and she was kept on bed rest for a week or more. Today she is often permitted to eat a full meal within an hour of delivery, and she is usually encouraged to sit up within a few hours and to stand within twenty-four. As a result, she is a much more active and alert patient than in the past.

The fact remains, however, that the mother has been subjected to strain and physiological alterations from which she does not immediately recover upon the birth of the baby. She must be watched closely for evidence of internal hemorrhage and her breasts checked against the danger of abscess and other morbid conditions. Sutures and incisions must be watched for normal healing. In other words, the possibility of complication is always present and the new mother needs to have nursing and medical skills available to her even when her recovery is routine. For this reason, a graduate nurse with considerable competence is usually in supervisory capacity over the post-partum floor. Since many of the duties are routine, however, a good bit of the work can be done by less skilled persons and one finds practical nurses, aides, students, and often nurses who had retired and then returned to hospital service, employed on these floors.

One nurse commented, "I hated it here at first; nothing but women, women, women." Most of the employees enjoyed the obstetric floor despite the imbalance of the sexes, but admitted that the work did tend to become monotonous in time. One new graduate remarked:

The most satisfying thing from my point of view is nursing a patient with something very serious that requires a great deal of care, such as a brain tumor. Now maternity work isn't so interesting. It is easier on you but you don't get the satisfaction that you get from taking care of a desperately ill person. When they are really sick, you feel that you have accomplished something when they recover.

Another young nurse, newly transferred, said with a smile:

Listen, it is almost like a vacation to be here after the busy medical-surgical floors. Of course it gets hectic at times, but then the slack times make up for it. Also, there is always a lot of joking and kidding

going on. I'll admit though that the work isn't as challenging. It would become rather dull routine after a while. The thing that makes it interesting now is that it is such a happy floor. The mothers are happy and the babies are wonderful. I'm just crazy about babies. And then relations with the students are good too. They are very eager to learn about this type of work, and I get a big bang out of them.

Another said:

I love the work with orthopedics myself. You can do so much. Just moving around the room and being cheerful makes them feel better, and I like that. You feel they really need you, whereas these obstetric cases don't need a nurse.

The routine quality of the care makes it possible for persons with less competence to adjust quickly and maternity floors are seen as a haven by some. One middle-aged woman told us:

I always preferred work on the medical and surgical floors because you handle different kinds of cases and meet so many different kinds of people. However, I came up here because it's easier work to come back to after being out of the hospital so long. Things don't change here so much. Of course they get the mothers up sooner than they used to, but otherwise it is pretty routine. I'd be afraid to work on the other floors now, I'm too out of date.

The sociability and lack of tension characteristic of this nursing floor were frequently mentioned as a source of satisfaction. Young nurses and mothers could be observed on this floor clustered together with much conversation and laughter among them. In the evenings fathers would visit the floor and there would be many signs of tenderness and much standing in front of the nursery window gazing with admiration at the infants inside.

Since the work was routine, social factors loomed large in importance. Any break in the monotony was made a great deal of, as in the instance of an irate husband who got the idea that his wife's newborn wasn't his own. He telephoned her during the night and aroused the entire floor by his bellowing, but the next morning armed with flowers and tears he was at her door begging admission. There was buzzing for days over that. Similarly any medical problem which arises is cause for excitement. Student nurses these days have only rare opportunity to observe obstetrical complications and they all wanted to be assigned to one woman who was threatened with convulsions.

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Nurses' aides and practical nurses, like the students, enjoyed work on this floor because of the relaxed atmosphere, although they too found it routine. When delivery room crises arose, as they did when too many babies arrived at the same time, the nurses would be pulled off the post-partum floors for delivery duty and the recuperating mothers would be left almost completely in the care of the auxiliaries. Problems were rare:

A few get annoyed because I'm not a nurse. They can't understand why I can't give them their medicine. I just have to hand it to them straight sometimes. I tell them that after all they have delivered their babies and should realize that when another woman is delivering, she needs a nurse more than they do. They should understand what that woman is going through and maybe another woman had to wait for the nurse while they were going through labor. Usually they take the lecture like lambs, you know. They quiet down right away.

No effort was made to survey systematically the attitudes of patients toward nursing auxiliaries. Those who did mention them said they didn't really care whether nurses or auxiliaries did the routine work. A private patient said:

They are all very friendly and helpful, and I'm sure I could get help quickly if anything went wrong, as far as that goes. Actually you see more of the other patients than you do of the nurses. The patients are all friendly too. I meet them out in the hall when I'm walking up and down. There really isn't much else to do besides writing thank-you notes and reading. Aside from that they try to keep us busy, giving us baths and meals and then feeding the baby, of course. Between times you walk up and down the hall more because you're bored than anything else, but that way you do get to know the other mothers who are walking around. It helps pass the time.

The doctors' work on the floor was light. Usually his orders were routine for all normal patients. Relations between the medical and nursing staff appeared informal and friendly with much joking and banter, and the doctors appeared to find this floor a place for relaxation.

The one person for whom the post-partum floor is not routine is the supervisor. Though attention to cleanliness and aseptic routines are at least as important here as anywhere else in the hospital, we saw violation of them here more than anywhere else. The informal atmosphere of the floor seems to mitigate against the observance of disciplinary

rules, except in the delivery room where the presence of the doctors and the surgical setting reminded people of the necessity for aseptic procedures. The supervisors had strict rules in the post-partum ward, and when they hammered away at them incessantly, people would take care at least as long as the supervisor was on duty.

The supervisor had other problems. It was part of her responsibility to handle public relations aspects of the work and on obstetric floors these are more sensitive than elsewhere. There are legal matters, such as getting birth certificates filled in on time, and that involves corraling the doctors long enough to get information on the techniques used in delivery. Her work includes getting certificates of paternity where there is an element of doubt, and notifying the newspapers of legitimate births and supervising the keeping of statistics on newborns, stillbirths, and deaths. It is the supervisor who accommodates the representatives of various religious faiths and provides them with the privacy necessary for the appropriate ceremonials. She is the one who discusses with the mothers such matters as hospital regulations about tubal ligations. It is her task to cooperate with social workers in the placement of unwanted infants, or the care of mother and child after they leave the hospital, when that is necessary.

The brunt of discouraging unwanted visitors also falls to her. In the hospitals we studied, it was felt desirable to keep the number of visitors down and privileges were officially restricted to the father and grandparents of the new baby. However, in some cultural groups it is the custom for *all* of the relatives to hurry to the hospital upon the birth of a child. It is the floor supervisor who must convince them that for hygienic reasons their ceremonial calls should be postponed until mother and child are in their own home.

The responsibility for teaching student nurses may lie with the floor supervisor, or the clinical instructor. Usually both of them are involved, at least to some extent. Teaching is easier on this floor because students are usually eager to learn and because the work is relatively simple. On the other hand, there are psychological problems which may arise which are less likely to appear on other floors. It is difficult to explain to an innocent mind why the world isn't a more orderly place. A student must be convinced sometime during her training that it is not her place to sit in judgment of her patients' private lives, but rather to restore them to health and to keep her own counsel. This growth seems to occur more often on obstetric floors than elsewhere, perhaps because problems present themselves so in-

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escapably. We saw them handled with tact and effectiveness by skilled instructors. Here, too, the social worker and student nurses were brought together informally to discuss how nursing and social service departments join to handle patients' problems. They learned from the social worker and the supervisor how the hospital was linked to other community agencies through legal ties, processes of adoption of children and the care of underprivileged infants.

It seemed to us that it was on this floor where many students achieved poise in the role of nurse. Perhaps it was due in part to the fact that they felt competent to handle the routine with a minimum of supervision. It may also have been related to the fact that they developed a more mature relationship with the doctors than they had had before. By the time the average student reached her maternity assignment, she was in her junior year and about twenty years of age. She was losing her initial timidity around physicians.

The alternating periods of intense cooperation in crises, and informal relaxation between, developed bonds between the student and other workers just as it did for the graduate. Informal clustering participated in by graduates, students, internes and doctors were frequent on the post-partum floor but relatively rare elsewhere in the hospital.

The nursing auxiliaries were rarely incorporated into these informal discussion groups. Even when they were in the same room, they tended to keep a respectful distance. They seemed, however, to be more fully a part of the nursing team on this floor than elsewhere. Their work was often restricted to the post-partum section of the floor, except during emergencies when almost anyone could be brought in on a labor case, but during slack times the entire nursing group was sometimes drawn together over routine tasks. It was then that house-keeping chores were tended, linen folded, packs made for the delivery room, instruments cleaned, babies' identification bracelets strung. Many of these tasks require little concentration and allow thoughts to wander and conversations to spring up. Such chores were usually assigned to auxiliaries or students but one sometimes saw supervisors, internes, graduates, students sitting around a big work table together. In this way they learned one another's interests, work tempos, and ways of doing things. When rush periods came, they knew how to work together because they understood one another and knew what to expect. It is easy in such an atmosphere for habits of cooperation to grow.

On other floors where the work tempo is more even and where each employee is assigned to a specific portion of the work, there is less occasion to either give or ask for help, particularly across status lines. Although spontaneous cooperation occurs, the situation doesn't encourage it to the same extent.

The division of labor between sections of the obstetric department is one of the few sources of friction. If nurses were not given definite assignment, the post-partum mothers were apt to be neglected while the nurses went to the more interesting delivery section. Where nurses were assigned to it on any long-term basis those given post-partum care became discontented and either grumbled or quit.

We used to have three graduates working on each shift but that didn't work out either. The one on the post-partum floor fussed continually. There were always arguments going on. It really was more of a headache than a help to have her. Finally she got herself transferred to another floor and we are back to two graduates on each shift. We divide the work among ourselves so that nobody is stuck with the mothers all the time.

In some instances, work in the labor room was attached to that of the delivery room and handled by one corps of workers while post-partum and nursery wings were looked after by another. It seemed to us that there was a fallacy in this which grew from the psychological differences in the work. Good delivery room nurses, like good operating room ones, tended to concentrate on manual skills. That is to say, their attention was riveted, perhaps of necessity, on physical techniques of patient care. Labor work corresponded more to that of medical floors in that the demands on the nurse were much greater in the psychological area.

The relative esteem of the various sections could be seen in the way work was divided when it was left up to the workers themselves. The nurse with most seniority took the delivery room, the next took the nurseries, and the newcomer got the post-partum mothers. It was the graduate nurses doing post-partum work who expressed the most anxiety about professional competence. They felt that they were looked down upon in other parts of the hospital:

If you are sent to work on another floor, the nurses will make remarks, "Oh, you come from *annex*," as if since you come from the annex you couldn't be expected to know how to do anything.

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While they were building up competence in their own specialty, they were acutely aware that they were not keeping abreast of other developments in nursing:

After three years on this floor I didn't know any of the new treatments being given on the other floors and it was embarrassing. My friends would ask me about this new drug or that treatment and I didn't know the answers. I wanted to keep up with the profession so I was glad to go to the Vets hospital and have a chance to do it. Now I feel I'm up to date again so here I am back on OB, which was always my favorite.

Another source of tension, also relatively minor, was found in the relationship between the post-partum floor and the administration. Just because there are slack periods when people sit around over small chores, administrators may get the notion that are too many people at work here. The delivery room must be kept adequately staffed day and night, but workers from the post-partum section were sometimes borrowed to help out on other floors to relieve pressing shortages of help and this left the floor very shorthanded at times. It is difficult to convince someone that the number of post-partum patients is not to be correlated with the amount of work to be done. Actually three newly delivered women require a great deal more care than a half-dozen mothers who are about ready to go home.

Summary of Observations on the Post-Partum Floor

The patients in this part of the obstetric department are young women, relieved of pain and looking forward happily to the future. For this reason, post-partum work can be fun. Patient care, to a notable degree, does not cause tension but there is a lack of challenge in it which is a real disadvantage. The nurse who has not kept up with changes in techniques may find security in the routine quality of the work. Others may find it boring and worry about losing their all-around competence.

This is a difficult floor to supervise. The patients participate actively in the life of the ward. The nurses differ widely in age and training. The informal atmosphere appears in some instances to encourage relaxation of discipline and carelessness in the observance of aseptic techniques. Many aspects of public relations for which the supervisor is responsible call for knowledge and finesse. For these reasons her position is worthy of considerable recognition.

The Nurseries

If post-partum patients tend to be uncritical and easy to get along with, this is even more true of the babies.

This is going to sound awful, but it is the truth. I like working with babies because you don't have to take any back talk off of them. You can get awfully tired of taking a lot of guff off the patients downstairs. With the babies you can plan your work and go ahead with it, knowing that there will be very few interruptions. Of course some of the girls complain because there is so much routine, and there is, too, but if she gets bored, she can always go out and talk to the babies' mothers. Also, you have students to teach and that helps. They're young and interested, and most of them are crazy about working in the nursery.

Another nurse commented similarly:

It's easy on the nurse here. You don't have to adjust to a whole group of people like you do on other floors. For that reason I prefer to work with the babies.

While babies do not talk back to the nurses, they do make their demands known and upon occasion very vehemently. They respond very differently to different nurses. An experienced woman told us that the infants sensed it when their attendants were anxious or treated them gingerly. They quieted down when someone came in who was accustomed to children and had the right combination of assurance and fondness for them. One of the nurses was praised by the doctors as having a way with children. Although she claimed to be hard-hearted, she never failed to mother a fretful child. Her touch seemed to bring peace to the babies. Despite her assured manner, she protested most vigorously about the lack of supervision given to nurseries.

I have always resented it. It seems to me that they neglected the babies. For my money these kids are the most important people in this hospital. After all, in other departments the patients can complain if they are mistreated, but the babies are defenseless and it isn't fair.

One aspect of infant care which receives careful attention in some hospitals and is neglected in others is the child-mother relationship. For example, the student nurses told one interviewer that a baby was in trouble because his mother was "nervous." We observed the mother giving her child his bottle and saw that she held him almost at arm's length, as far away from her as she could get him. In the nursery this

child was much more fretful than the others. Where they returned from their feeding time and fell promptly asleep, he lay awake crying and thrashing his little arms. Although the nurses suspected that his distress was aggravated by the emotional attitude of his mother, there was no effort made to get her psychological help. In another hospital a mother wept bitterly when it came time to take her child home. She protested that she was afraid of it and sure it would die. In this case she was given every reassurance by the nurse in charge of the infants. She was told that she could telephone the nursery any time she felt at all uncertain of procedures. She did telephone six or seven times during the next few days and was patiently given information and psychological support each time and the calls gradually were spaced farther apart and then ceased. A nurse with as much understanding, in a busier nursery, might have been unable to find time to give as much personal attention to a discharged patient. So far as we could see, such problems were being left completely to the discretion of the individual nurse.

Though the care of normal infants is not always looked upon as demanding special skill, the nursing of prematures has recently become a specialty with considerable recognition in larger hospitals where there are special nurseries devoted to this work. To an observer, the care of prematures seems very tedious. The nurse is isolated from everyone else in the hospital. She has long periods of relative inactivity but must be constantly alert and ready to fly into action. Despite these drawbacks, we found that these nurses had very high morale.³ One nurse said:

It keeps you busy even with only three babies to attend. They need to be fed every hour. Sometimes they are fed every half-hour when they are newly born. I had seven babies to mind once and almost went crazy. Heavens no, I never get bored, not with the babies to take care of. I'm just crazy about it. Of course, you can't leave them for long. I do stand in the door once in awhile and chat with the other nurses but you have to keep your eyes on them constantly. They will start to turn blue because something is caught in their throat, maybe just a speck of mucus and you have to be right there to give them extra oxygen or suck it out or it is just too bad. A new one you can't take your eyes off for a minute. I think they are wonderful. Of course, I always loved babies anyway.

³ For further evidence on the satisfaction to be found in this line of work, see "Nursing Services in a Premature Infant Center," published by the Urban Life Research Institute, Tulane University, 1953; especially chapter III by Virginia H. Walker.

Another nurse said:

I love this work. It gives you a wonderful feeling. There is more satisfaction in it than any other kind of nursing for me. Now you take Peewee over there. She only weighed two pounds when she was born and later her weight went down to one pound thirteen ounces, and yet we pulled her through. Dr. Jacks worked awfully hard to save her. Maybe that's why we are so terribly proud of her. We had to work so hard. Now she weighs three pounds and is doing fine. Look, isn't she cute! [She looked like a starved bird.]

An important cause of the high morale seems to be the recognition nursing prematures receives as a specialty, and we found less satisfaction where this recognition is not given. For example, one nurse commented:

I have been after them for a long time to give me special training. The pediatrician told them that they should train all of us who work in the nursery and that we should have a special course in premie care. I'd like it very much, but the hospital just isn't interested. Well, it's their problem, that's all. The way I look at it, if any one of our premies die, I just don't feel bad about it any more. It's the hospital's problem. If they wanted to save those babies' lives, they would send us away and teach us how to take better care of them. To tell you the truth, the way I feel about it now, I'd take any good position that was offered to me any place. There is really no incentive for staying around here.

One may read between the lines how very much this nurse did care when a child died. This is one among many instances of the anxiety felt by hospital employees who have been unable to keep fully abreast of advances in patient care.

It is, of course, difficult for the smaller hospitals to keep up with the rapid strides in medical technology. In one situation an administrator commented:

Now this obstetrical group has got the idea that their premies should have a special nurse. Those doctors want us to have a private nurse on duty around the clock. That would cost \$9.00 per day for each nurse, now how many families could afford it? The doctors felt that if the family couldn't pay for it, the hospital should provide it anyway! They just don't think, now, do they? They just see that there are too many premature deaths. See, as it is, the premies get the same attention that the normal babies do. That means that if the nurse turns her back on them for a minute, a child may choke and die, whereas if they had a

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special nurse the baby would be saved. It would be a confoundedly expensive business, especially when there would be just one premature child at one time. If we had four, we could charge each mother one-fourth of the total cost, that wouldn't be so bad, but how about when there is only one?

Problems like this are dealt with ultimately, and it is usually some compromise arrangement which is agreed upon. Meanwhile, however, tempers may flare. The administrator accuses the doctors of refusing to face the realities of financial limitations and medical personnel clearly imply that administrators are wanting in humanitarian instincts. Actually, in many instances, there is no real conflict of values but a much more prosaic problem of figuring out ways and means of doing what everyone agrees must be done.

Summary of Observation in the Nurseries

While babies can make vehement demands, for the most part their care is easily encompassed by an experienced nurse and a good deal of satisfaction was found in it. The nursing of prematures was especially enjoyed, perhaps in part because the work was important and intrinsically satisfying, and partly because feelings of competence and status resulted from training in a new specialty. Frustration was expressed by medical and nursing personnel who were not in a position to keep up to date with latest developments.

In some of the hospitals, help for the new mother in her adjustment to her child was left to the initiative of the individual nurse. We saw almost no organized effort to make sure that mothers who needed help got it, or to train nurses to give it.

Nurse-doctor relations were good just as elsewhere in this department, and supervision tended to be minimal.

Other Aspects of Maternity Work

Discussion of the obstetric department would not be complete without mentioning the many other people who work to keep it running smoothly.

Some states require that a formula room or milk laboratory be maintained and operated by a special attendant. This work requires conscientious attention and reliability and the attendant in charge may be ranked as a technician or practical nurse. If there is an open medical staff at the hospital, she may have a wide variety of formulas to prepare,

but usually there are a few which are used routinely with variations only for babies who are having feeding problems.

The work of the maids may be somewhat more complicated than elsewhere in the hospital. When infants are roomed in with their mothers, the maid must wear a surgical gown and mask when she cleans the room. If they are kept in the nursery, the maid will have to know when feeding time is, in order to have her work finished before they are brought to their mothers. Maids, like nursing auxiliaries, expressed satisfaction with work on this floor. They appreciated the sociable atmosphere, the friendly patients, and the lack of visitors.

You don't have to ask people to pick their feet up so you can sweep under them. And I get a kick out of seeing the babies.

In several hospitals a receptionist helped the supervisor to keep track of paper work. She looked after birth certificates, statistics, and answered the telephone. This last was her most irksome task, for in some neighborhoods it is evidently considered socially necessary that all friends of the mother telephone the hospital at intervals to inquire whether the child has arrived. The receptionist also greets the incoming mothers and escorts them to bed, and shares with the supervisor the difficult task of enforcing restrictions on visiting privileges. She may be the one who deals with the anxieties of expectant fathers.

In one hospital a matronly receptionist was the only employee on the floor over the age of twenty-five. In addition to the tasks we have listed, she was the center of social life among the mothers who were able to be up and about. She was the one who mothered the younger ones and those whose babies were born out of wedlock.

We heard hints dropped, from time to time, to the effect that the constant reminders of motherhood cause frustration in unmarried nurses or women in menopause, single or married. There was evidence of occasional hostility on the part of such persons, but we saw enough exceptions to be suspicious of generalizations. However, in all of the hospitals there seemed to be a policy of employing young married women, and especially pregnant ones. Pregnant nurses felt self-conscious on other floors and frequently asked to be transferred to obstetrics for that reason, and it was believed that the easy rapport possible between them and the patients made them excellent workers. The doctors whom we interviewed thought that the best maternity nurse was the young, flexible graduate who was open to new ideas.

General Conclusions

In discussing the obstetric department we have tried to show something of the multiplicity of factors which influence the human environment of any hospital floor. There is in the first place the nature of the work itself. When jobs are essentially solitary ones, the response they elicit is different from that called forth by a closely knit team. Special training and a feeling of competence which results from it makes work enjoyable even in the absence of team stimulus. A distinction can be made between work calling for technical skills and that where the emphasis is more on psychological aspects of patient care. The unevenness of tempo on the obstetric floor was shown to influence work relationships. So also were symbols of importance, including not only brightly lighted workshops and intricate tools but perhaps most importantly the presence of highly respected members of the medical staff.

We have indicated the interrelatedness of occupational groups and the influence of hospital policy and organization. Where the medical staff is well organized and a reputation for a high level of performance is maintained, human relations patterns on nursing floors are influenced in a positive direction.

The physical and psychological needs of the patients were seen to influence the satisfaction which various nurses found in their work, as well as to help determine the general morale and level of activity on a nursing floor. Visitors also were shown to have their influence, and differences in cultural patterns were seen to affect even such elementary phenomena as reaction to pain.

All these things together help to determine the scope of the supervisory task; the kind of discipline necessary, the level of difficulty to be expected in achieving smooth coordination. It is hoped that these factors will come into clearer perspective when we come to discuss the contrasts found on medical and surgical nursing floors.

A COMPARISON OF MEDICAL AND SURGICAL FLOORS

IN THE PREVIOUS chapter we pointed out that the work of the nurse differs considerably from one type of hospital floor to another. Strong expressions of preference made by the nurses bring out this factor.

Give me surgical work any day. They get better fast and go home. I always hated it on medical. Even when they get better, you don't always know how much you have had to do with it. Maybe it was just all the bed rest.

Give me medical. On surgical floors all you do is take care of the physical ailment. You hardly ever take the psychological into consideration. I'm definitely not interested in surgery, it's too mechanical a type of work, like running a lathe.

The focus of this chapter will be on contrast, but it should be kept in mind that on any nursing floor there will be similar needs for intelligence and imagination and many types of theoretical and practical knowledge.

Technology and Working Conditions

In some of the larger hospitals whole floors are given over to specialized services, such as orthopedics, urology, or eye surgery. However, we shall concentrate on the differences between the two main categories, surgical and medical.

Medical floors look different from surgical ones. They sound different, they have a different feeling tone. Much of this is due to their respective technologies. On surgical floors there is an abundance of apparatus such as dressing carts, bandage trays, and orthopedic paraphernalia. The convalescent patients are usually stirring about, often in wheel chairs or on crutches. The dominant note is one of activity and bustle.

The medical floor, in contrast, seems quiet. Even early in the morning while surgical floors are still buzzing with morning care, medical patients will be found in fresh and clean beds, their rooms in order. There are no complicated bandages to be changed, little machinery to be pushed about. The patients stay in their beds and convalescents go home before they feel well enough to do much visiting with one another.

The things which a nurse does on the surgical floor are frequently of recognizable importance, even to patients who are strangers to hospital activities. When a patient sees his nurse changing bandages or swinging orthopedic frames into place, he can realize that these are purposeful activities and can accept her absence when he sees her tending to another patient's needs. When she fumbles in working near a fresh incision, the patient cries out and everybody knows she has made a blunder. Therefore, blunders do not often occur. The nurse's skills are tested daily and both her feeling and her prestige rise as she becomes more adept.

Medical nursing is also highly skilled. Nurses sometimes claim that the physician is more dependent upon them than the surgeon is. The surgeon can often make his diagnosis from the history and immediate physical and laboratory findings, whereas the physician may need a record of careful observation of the changes in the patient's symptoms through time. The nurses on the medical floor provide these records but this is an activity which is not visible to the patient.

This lack of visibility creates problems. The patient sees his nurse stop at the next bed to chat for a moment or two, but doesn't know that she is observing the quality of respiration and the color and tone of the skin. He thinks she is just visiting. Her activities are not very impressive to the uninitiated. He feels she is wasting time unless she is darting about doing something visible, such as administering hypodermics. He can judge the quality of the care he receives only on observation of his nurse's ability to make him feel comfortable and her willingness to answer his bell when he summons her. Actually his

mother, in all probability, would do a better job at both. His mother could not make the accurate notes which his doctor needs, but he is unaware of the great importance of this nursing service. It is not only the patient and his family that misplace emphasis. The difference between a highly competent and barely average medical nurse may be quite apparent to the physician and to other nurses, but be lost on the administrative personnel of the hospital. Even surgical nurses occasionally may be heard to say contemptuously, "All they do over on medical is make beds."

Thus, technological factors influence the human environment of a hospital floor. At the beginning of our study we suspected that mechanical equipment might be frightening to patients. We found so few examples of this and so many evidences of confidence and even of pride in the use of contraptions that we had to reverse our hypotheses in favor of machines rather than against them. This is possibly peculiar to Americans, who have the reputation of unusual respect for mechanical gadgets. Also, our observations seem to support the notion that Americans are biased in favor of activity for its own sake. The opportunity on surgical floors for sheer busyness and for the demonstration of technical skills appeared to give satisfaction to the nurses and assurance to patients.

Patients

Nurse-patient relationships have been drastically influenced throughout the hospital by two great technological changes. The first is the introduction of the new antibiotics. One of its effects is that of increasing the confidence of the patient, for he frequently holds the widely heralded drugs in deep respect and welcomes them as curative agents. On the other hand, he may develop a dread of the nurse as a needle-bearer. In one extreme case, a patient reported his private duty nurse for being a sadist. When he was interviewed by the director of nurses it was found that he had never seen his nurse except with a needle in her hand. He had built up an exaggerated fear of both nurse and needle. When the physician learned of this, he substituted oral for intramuscular medication and the patient reported later that he and the nurse were getting along fine.

While antibiotics are used on all floors, they have made the greatest difference on medical ones by so reducing the number of acute infections that these floors are now dominated by chronic illnesses such as the disabilities of old age.

The second great technological change has been the trend toward early ambulation. While this has affected medical floors to some extent, it has revolutionized the work of the surgical nurse. The theory of early ambulation is that early activity of a patient following surgery reduces the frequency of late complications. It also, however, seems to embody a philosophy of self-help. This was revealed in the attitudes of some of the nurses, who observed their patients making more rapid recovery, hence going home faster.

One of the biggest changes has been this business of having the patient take care of himself as far as he is able. In the old days we did everything for them, even to washing their faces, but now they are supposed to do as much as they can for themselves and I think it is the best thing that ever happened. When you lie in bed and have nothing to do but think about yourself, all you do is lie there and think up symptoms. Every day they would come out with a new set of symptoms. Now they are too busy for that. They are washing their faces or preparing for lunch or they're taking a walk down the hall or going to the bathroom. It keeps them out of mischief. Maybe that sounds awful to say it, but I really think it is the truth. I really think they adjust a lot faster and it makes all the difference in the world for the nurse.

Another nurse, recognizing the same change, bewailed the effect it had on nurse-patient relations.

We don't get acquainted with them any more, the turnover is too rapid. We used to have a more homey atmosphere. The patients would show us pictures of their families and we would get to know their whole life histories. Now we are losing contact with the patients.

Regardless of the nurses' attitude toward it, quick patient turnover seems to be important in shaping relationships, particularly on the surgical floors. Nobody gets bored, the nurses say, but apparently nobody gets much opportunity for deep emotional involvement either.

Surgical nurses comment approvingly on the fact that they have a wide variety of patients. Automobile accidents are no respectors of age or condition of life, and anybody can have an inflamed appendix, so general surgery does indeed get a wide span of age and socio-economic levels. Medical floors, on the other hand, tend to acquire elderly patients with heart and circulatory diseases, cerebral hemorrhage, diabetes, asthma, cancer, ulcers, and other chronic diseases. Not only are the diseases lingering but the patient is likewise. Many of these cases respond slowly to treatment, the prognosis is poor, and patients require

much custodial care such as baths and frequent changing of bed linens. The work tends to be heavy and routine and the tempo of the department is even and slow. A large proportion of the patients, in addition to being elderly, are poor—for it is poorer families, unable to provide for their aged at home, who must ask the hospital to give them prolonged custodial care.

This may make medical floors sound more depressing than they are in reality. It is sometimes assumed that the care of the older person represents great self-sacrifice on the part of the younger nurse, but we found that it isn't seen that way by everybody. Some of the nurses insisted that older people were "cute," by which they evidently meant small and helpless and appealing to the maternal impulses. Since these patients tend to have prolonged stays in the hospital, they become well known, and lasting ties of affection sometimes form. One elderly lady was the psychological mainstay of the entire ward, nurses as well as patients. A delightful person, she kept the entire room in brisk cheerful spirit.

Several medical floors were found to have "pets"—patients of long standing who had won permanent niches for themselves in the hospital social system. One of these was nicknamed "Granny."

Granny is eighty-nine years old and stone-deaf. The nurses can't decide whether she is senile or foxy. She pretends she doesn't know one nurse from another, but if anything goes wrong, she always knows the culprit by name. Granny used to be very selfish about her few possessions. However, one nurse discovered that Granny had no recollection of pleasant Christmases and so arranged to give her a surprise. The floor staff conspired to set up a small tree and each staff member placed under it a little gift for her and then Granny was wheeled out to the sun porch to see it. She was so surprised that she was like a little child. Her face shone with happiness and from then on she insisted on sharing every tidbit she had with the nurses. It was plain that these nurses were fond of this ancient and sometimes difficult patient. They would stop by her wheel chair to comb her hair or to pin a flower on her shoulder. She became very spoiled and the nurses would comment at the dinner table on how Granny had scolded all morning because they had bathed a woman down the hall instead of tending to her first.

In contrast to the chronic case is the acute infection. While these are distinctly fewer in number than before the antibiotics came into wide use, they still appear on medical floors. The pneumonia patient doesn't always respond to the new drugs, the polio patient needs the closest

attention, and a patient with an undiagnosed infection may require expert care. In interviews nurses indicated that these cases were often sources of keen satisfaction. Evidently when such a case responds to nursing treatment it vindicates all the training and hard work of nursing.

The sicker they are, the better you feel about it. When they get better, you can feel you had something to do with it.

Now that is the kind of case that makes me glad I went into nursing. He was desperately ill and we thought for sure he would die, yet here he is well enough to leave the hospital again. That is a real thrill to me.

When they are very sick, they can be very nice to work with. The others who are up and around and still demand extra services are the ones who get me down.

It appears that the sickest person is more gratifying to care for just because he does need the nurse most urgently. His needs excite her deepest emotional response and greatest efforts.

The medical floor, then, gets a high proportion of older patients and chronically ill ones, but the presence of some acutely ill cases helps to relieve the monotony which might otherwise present itself.

The psychological relationships which come to exist between nurses and their patients is a fascinating study in itself. We found that on surgical floors, doctors and nurses alike seemed to concentrate attention on the patient's incision, i.e., on his physical need. Whatever else might be wrong with him, their immediate business was the healing of surgical wounds, and in this day of antibiotics and early ambulation wounds heal quickly. The patient has neither time nor psychological need to develop a lasting dependency on his surgical nurse. Moreover, the typical surgical patient appeared to assume that once his operation was over, his crisis was passed. The cheerfulness and release from private worry which resulted made it easier for him to turn readily to his neighbors. Surgical floors were characterized by camaraderie in all of the hospitals studied. The patients entertained each other, played games, bantered with one another and the nurses, and helped to look after each other's minor needs. There were exceptions, of course, but in general this was the case.

The medical floor contrasted sharply to this. The presence of many aged persons may have had something to do with it, but we found many patients who showed querulousness and the emotional depend-

ency of children. The older person in our society frequently lacks any clear function in the family and in economic life, hence may fall easy prey to melancholy. Furthermore, unlike the surgical patient who passes his crisis early in his hospital stay, the medical one typically still faces his crisis; once it has passed he is likely to go home for convalescence, since his care usually does not require much technical apparatus. Therefore, during his hospital stay the medical patient is characteristically wretchedly ill, worried, and not likely to concern himself with the needs of his neighbors.

Logically one might suppose that hypochondriacs would appear in equal numbers on all types of hospital floors. In actuality, however, psychosomatic symptoms were commented on much more frequently on the medical ones. On surgical floors, it seemed to us, the patient with possible personality problems was accepted on the same basis as everyone else. Shortly after his arrival he acquired a perfectly bona fide incision which was the focus of attention. Perhaps psychosomatic symptoms actually fade in the presence of a physical injury. At any rate, the nurse and doctor as well as the patient appeared to assume, at least for the time being, that the real basis of the patient's complaints had been found and attention to any other possible problem was postponed until after his recovery from surgery.

On medical floors, where ills were more frequently of the invisible kind, it was easier to attribute amorphous complaints to the imagination. It was not unusual to find on a patient's chart a report of some tedious bit of behavior, followed by the question, "Neurotic?" On the chart, one surmised, the nurse or doctor could release the feelings of aggression against difficult patients. Sometimes one's sympathy was much with them. For example, a patient who had been calling for repeated sedatives was found to respond as well to tablets of aspirin as to morphine. A medical resident made this entry on her chart at 2:15 A.M.:

Would suggest that this patient's private physician give her either a harsh lecture or psychotherapy of some sort as she is running her private nurse ragged, which is transmitted to the house staff at rather awkward hours.

Such patients were inevitably compared with others who bore their ills with stoic fortitude. One man who walked into the hospital and who continued to be resolutely cheerful and helpful was found to be

suffering from possible rheumatic fever, enlarged heart, impending coronary failure, a blood disorder which resembled leukemia, and renal pathology. How could the nurses fail to recognize the difference in adjustment of these two patients who were on the same floor at the same time? Nurses appeared to find these variations in psychological condition either a source of satisfaction or a trial, depending on their capacity for sympathy and flexibility. Some nurses expressed decided preferences for medical nursing just because the psychological aspect occasionally presents a knotty problem. One commented that she had always enjoyed detective stories and thought the same kind of mental exercise lay behind her satisfaction with this type of work. She "just loved to figure people out."

Another, who worked on a floor of mixed medical and surgical cases, said:

If you like people, you get to know them better when they're medical cases because they stay in the hospital longer and really become personalities to you. Also, their care is less dramatic than surgical work but it is more challenging, too, because you have to figure out what ails people and try to understand their personality and how the various drugs affect them. It represents more of a challenge to the doctor and to the nurse, too.

To summarize, surgical patients characteristically are horizontal only for a limited time. Then they are up and about, active in their interest in others, and relatively cheerful in outlook. They come from a wide variety of backgrounds and age levels, turn over fast, and thus present constant variety and change to their nurses. The nurse-patient relationship is usually focused on physical rather than psychological needs, and the nurse's service is of easily recognizable importance.

On medical floors there is a greater proportion of older patients, and thanks to the new antibiotics they are more apt to have chronic than acute ailments. The turnover of patients is therefore less rapid than on surgical floors. Nurses and patients get better acquainted and psychological factors loom larger in importance. Because both the need of the patient and the service of the nurse are less obvious than on surgical floors, there is more room for uncertainty with respect to them. The problems which result may be a source of annoyance or of fascination for the nurse, depending upon her own personality makeup and psychological state.

Work Organization and Human Relations

In some departments a spirit of teamwork develops naturally because of the nature of the job. A variety of employees may each contribute their particular skill with very little overlap. This is true on the surgical floors. In addition, the surgical patient seems to recover at a predictable speed in a gratifying number of cases. For example, it can be expected that after a particular type of surgery a patient will be sitting up within twenty-four hours and allowed to dangle his feet over the bedside within forty-eight hours. The head nurse can plan the work of the department well in advance, assigning her most expert workers to the sickest patients and giving each nurse a reasonable amount of work and no more.

On medical floors such precision is more difficult to obtain. The patient's progress may fluctuate because of such things as the nature of the disease, variable reactions to drugs, and his psychological state. He will have good days and bad and his nursing needs will differ unpredictably.

On both medical and surgical floors it is customary to assign the most seriously ill patients to the graduate nurses. On surgical floors this means that the graduates tend the patients who have come most recently from the operating room. Student and auxiliary nurses, assigned to assist them, have an opportunity to work closely with these graduates, observing them respectfully as they perform their sometimes precise and difficult tasks. But they too have their own areas of competence. The aide, for example, may have had special training in making up postoperative beds or in methods of assisting an ambulant patient to move about his room. Jurisdictional lines are usually well marked and understood and each employee can see how his work fits into that of the others. Because surgical floors commonly have an abundance of hard physical chores, each pair of hands is welcome. The graduate nurses typically are given the direct supervision of the less skilled, but once they have determined the level of ability of a new employee they make appropriate assignments and let the subordinate develop further skills as occasion permits. In their interviews with us, student nurses commonly expressed satisfaction with surgical work.

Oh, I like surgical floors best. It is important work and you can see the results right away. In addition to that it is especially good here because the graduates are so nice to you. They make you feel you are important.

I don't know how to express it exactly, it is just that it is a challenge. It calls for skill and yet you are competent to go ahead with the work on your own and the nurses let you do it.

This student points to a number of factors influencing satisfaction. "It is important work." Surgical work is what a nurse's work should be. She has pictured herself by the bedside of an unconscious patient still smelling of ether, and completely dependent for survival upon her care. "The nurses are nice to you" and "It calls for skill and yet you are competent to go ahead." These statements reflect the fact that the competence required for different aspects of surgical nursing can be clearly graded. The half-trained student can use her newly acquired "nursing arts" and yet realize that the graduate has skills beyond her own. In other words, she can feel more useful than a layman and yet not put herself on the level of the nurses with superior training and experience. This promotes a relationship of respect between the two nurses.

On medical floors, students lamented, they too often found themselves "making beds while the graduates do all the interesting things." This happened, we observed, because the graduate, in caring for the seriously ill, usually chose the acute cases leaving the chronic ones to the care of students and auxiliaries. Chronic and acute cases require widely different care. Students and auxiliaries complained of the heavy burden of tedious custodial duties, the endless bed-making and water-carrying, and the fact that they thought they weren't learning anything. It was hard for them to see any significance in their work unless an experienced person pointed it out to them.

Part of the difficulty in the graduate-student relationship on some medical floors seemed to us to lie in the incapacity of the patient to adjust to a variety of persons. On surgical floors it was possible to utilize the diverse skills of aides, nurse assistants, practical nurses and students as well as graduates. The sociable mood of the patient recovering from surgery seemed to dispose him to enjoy the variety of attendants, just as he drew satisfaction from the companionship of other patients.

On the medical floors, the situation was different. Many of the very ill patients seemed to cling to one attendant, sometimes a graduate nurse, sometimes the lowly nurses aide who had first put him to bed when he came to the hospital. Relationships with several different employees seemed to upset them. However, we suspect the tendency

to form patient-attendant pairs was not only a response to patient needs. We noted that some nurses seemed to get deep satisfaction from caring for a particular patient. They would comment that a long-term patient became "almost like a member of your family." The experienced medical nurse, moreover, realizes that to a very ill person every act of the nurse is a part of therapy; bed-making and back-rubbing become part of psychological care. Feeling this, the nurse isn't likely to want to share the care of such patients with unskilled or semiskilled persons. There were exceptions to this, certainly. It was necessary to rotate the care of some patients because no one employee could tolerate them day after day. But a special relationship between one patient and one attendant occurred so often that we suspect that the rotation of patients frequently fails to meet the psychological need of both patients and employees.

On some medical floors we found excellent relations between graduates and student nurses. These were the floors where a senior person—either the head nurse or the clinical instructor—took the time to counsel the students and develop their appreciation of the subtleties of patient care. In one case the instructor made a game of clinical observation. The students learned that when they bathed a patient, the job wasn't completed until they had noted the color of his skin, the clearness of his eyes, and other physical signs. They learned to make a careful study of the personal history, psychological outlook, and medical diagnosis of each patient. Impromptu conferences held when the floor work was at a low ebb became so popular that the graduates began to attend them and staff nurses from other floors began to ask permission to sit in on them on their own time. Such conferences, or ward classes as they are sometimes called, take time out of a busy day and time is sometimes in very short supply on a busy nursing floor. Therefore they can be resented by both students and regular staff if they are handled unimaginatively. In many respects, therefore, the supervisor of a medical floor must exercise unusual leadership and skill, for she cannot assume that her workers will be woven together as spontaneously into an effective team as on surgical floors.

Work organization has an effect also on doctor-nurse relationships. One head nurse who was transferred from an orthopedic to a medical floor commented on this:

My favorite always was men's orthopedic. You can be systematic down there. It was a very busy floor, understand, but you could plan your work ahead. Another thing, the doctors were awfully nice down there. It's

funny, you take your urologists, your orthopedic men and your obstetricians, all of them are very nice and easy to get along with. They are nothing like the men you run into in the O.R. or on the general surgical and medical floors. That's where you run into trouble. I don't know for sure why it is. We have discussed it lots of times among ourselves. Personally, I think it may be due in part to the fact that on some floors you can be systematic and on others you can't. You know that when a patient comes in that he will be operated on the next day and five days later he will be up and around. You can always plan your work ahead and the doctor can understand that. He can see that you are following a system. On the other hand, on medical floors and on general surgery the same way, you get a variety of patients and doctors. You aren't well acquainted with any of them and it is more difficult for you to organize your work. All the doctors come in with their own orders and each one seems to think that you are neglecting his patient.

Surgical floors then appear to differ according to the types of surgery they deal with. In addition, the role of the doctor plays an important part in determining the satisfaction of the nurse. Nurses reported that doctors differ according to their specialties. They didn't always agree as to how they differed, or which ones were to be preferred, but some generalizations were put forward more frequently than others. For instance, a medical nurse said:

I think surgeons are harder to get along with than medical men. There's a lot of strain in surgery. You might say the work here has a crisis nature and that makes the tempers flare up. Medical work is more sober and more steady in pace, and yet to me it represents more of a challenge too. I think the girls who like a lot of turnover and variety like surgical work, and the girls who like people enjoy medical, and doctors the same way.

A specialist in internal medicine discussed the differences between surgeons and internists. When asked what the bad parts of his work were, he replied:

The times of discouragement to me generally come when I have worked on a patient for a long time and then he dies, or when I diagnose one thing and it turns out to be something else. But mostly it is when they get sick and die; I've never adjusted to it. Maybe that's a confession of weakness; maybe a doctor shouldn't feel that way, but it saddens me very much indeed and that is when I wish I had gone into another type of occupation where I wouldn't have the feeling of guilt that I get now.

Later he went on to say:

I never asked a surgeon about it, maybe they get down occasionally too. On the other hand, they don't know their patients as well as we do. They are only in contact with them briefly, whereas the internist sees his patients over a long period of time and gets to know them as people and that makes a difference too. You can't help but get emotionally involved with them to some extent.

His belief was like the conviction of the medical nurses that they have a closer relationship to their patients than the nurses on the surgical floors. Perhaps they were unfair in this. We have seen surgeons and surgical nurses in tears because a patient's course took an unfavorable turn. However, it seems reasonable that length of acquaintanceship makes a difference. Where the surgeon has known a patient well he may react similarly to the internist. Possibly, too, the physical activity of surgical work relieves emotional tension. The busyness of a surgical floor may be therapeutic for the staff.

The relationship of the doctor to his patient and doctors to each other also has an important influence on the conduct of the hospital floor. A recurrent complaint of surgical nurses was that the surgeons didn't make "sufficient" visits to the bedsides of convalescent patients. This complaint may be due in part to the fact that many surgeons are greatly admired and the nurses wish to see more of them. While this charge was made at all of the hospitals studied, it was particularly frequent in the smaller institutions where the division of labor between the surgeon and the family physician has not yet become clear. In the larger hospitals the surgeon was directly responsible for the full care of the patients. In the smaller ones, the family physician or general practitioner was usually within easy reach, since he came to the hospital almost daily to visit his other patients. These doctors complained sometimes bitterly that the nurses and surgical patients insisted on calling them for free advice and service.

You know how it is. The family physician has to diagnose the case and refer the patient to the surgeon. Down here he is also the one to make the hospital arrangements and handle the natural emotional involvement of the family. He carries the patient and the family psychologically through the operation and takes care of the patient after the operation. And who do you think gets the money?

The nurses explained that the patient "turned naturally" to the physician he knows best. They said also that the modern patient is

increasingly sophisticated about medical and surgical matters, and asked penetrating questions. The nurse, carefully trained to sidestep such questions, encourages the patient to put them to his doctor instead and in the absence of the surgeon both turn to the physician.

When a chief of surgical staff was asked about this problem, he smiled and inquired whose job it was to decide how many bedside visits were "sufficient." He pointed to the steadily declining death rate as proof that nobody was suffering from lack of care. He and other surgeons with similar outlooks were prone to belittle the "social" side of their work. They begrudged the time spent in their offices and said that it was boring. Occasionally a surgeon would state wistfully that he wished he could spend all of his time in the operating room.¹ Not all the surgeons felt this way, of course. Some of them seemed to take their bedside visits in stride and painstakingly answered the questions put to them.

Other Nursing Floors

Other floors in the hospital may combine features of both medical and surgical work. On the orthopedic floor, while a large proportion of the patients are postoperative, their stay in the hospital is usually very much longer than that of other surgical patients. There is an opportunity for the development of relations between patients and nurses similar to that found on the medical floors. Ex-patients return at holiday time, for example, bringing gifts for their old friends among patients and nursing staff alike. The nurses would speak fondly of these "alumni" and often knew in detail how their lives had worked out in the face of their physical disabilities. We found that they were occasionally invited to ex-patients' weddings and went to some funerals, too.

Floors devoted to care of patients after eye surgery also are more like medical floors. The patients very frequently are bedfast, require a great deal of reassurance, and do not interact with one another as readily as on the general surgical floors.

Pediatric floors are unique:

Pediatrics isn't like working at all. You're always entertained. The kids adjust to you and your mood, whereas the adults demand that you adjust

¹ Something of this attitude was reflected by an operating room nurse who commented that, while her work was exhausting so that she envied the nurses in other departments, "the importance of it unfits you for the trivialities of bedside care."

to them. Here we can talk and laugh as much as we want and if we feel like being quiet we can do that, too.

Another aspect of pediatric work, we were told, is the difficulty of public relations. One pediatric supervisor said that her real problem was not in getting nurses who liked working with children—that was easy—but in finding ones who could work effectively with mothers. This indicates that the effect of visitors on human relations varies in importance and quality from one floor to another.

The floors where both medical and surgical patients were cared for differed so widely that we cannot make generalizations. We surmised at the beginning of our study that on such floors there would be a tendency to neglect the medical patients for the more exciting surgical ones, but we saw no evidence of this. Individual nurses differ widely in the sort of patients to whom they respond most readily. The type of supervision appeared to have a marked influence on the type of care given. In one hospital with two floors, both of which (according to administrative rules) were supposed to care for both medical and surgical patients, medical patients tended to be placed on one and surgical on the other. The surgeons preferred the floors where the supervisors maintained a high level of technical performance. The physician, on the other hand, seemed to be more impressed with working harmony. One of the physicians commented:

It makes a big difference who the supervisor is, and it might not work out the way you'd expect either. On the floor where they have those old battle-axes, the efficiency is high but that isn't everything. The nurses might be unhappy and taking it out on the patients. On another floor the efficiency might not be so good, but the nurses get along with each other and like the work and the patients better so that better psychological care is the result. For my part, I think that in treating medical cases the psychology is more important than the physical care is.

Summary

No matter how much they seem alike to an outsider, hospital floors are by no means identical. They are little worlds in themselves, patterned by work habits and technological change as well as by interpersonal relationships and the sentiments to which they give rise.

Among the contrasts are the differences in medical technology, the types of patients and their psychological needs, the relationships among occupational groups and the way their work is organized, and the

nature of supervision which they enjoy. We saw many instances of interplay between the personality of individuals and the kinds of role they were being called upon to fill, but the possible combinations were so numerous and our data so limited that generalizations are difficult to make. A great deal of careful work remains to be done before the relationship between personality and occupational adjustment can be seen in clear perspective.

No hospital, in all likelihood, will find all of the forces discussed here are operating in similar measure on their own nursing floors. One or more elements may be entirely absent and others may be overshadowed by more dominant influences. What we offer, then, is only an opening glance at complex phenomena.

THE OPERATING ROOM

Introduction

THE DRAMA OF THE operating room has thus been described by a nonmedical observer:

At seven o'clock in the morning, nurses have arrived on the surgical floor. They find maids finishing the cleaning of the operating suites and corridors. Notices of scheduled operations for the day are posted in prominent places, listing the patient's name, type of case, operating surgeon, and appropriate operating room. Orderlies and nurses' aides are wheeling small tables into the rooms, with sterile equipment laid out ready for use. The charge nurse assigns scrub nurses [those who will actually assist the surgeon] and circulating nurses [those who will perform general tasks around the operating room, such as fetching water and counting sponges] to their respective cases.

As the hour of surgery, eight o'clock, approaches, the scrub nurses are washing hands and arms in the small scrub rooms next to the operating rooms; when they are thoroughly washed, according to specific procedures and an allotted time, they slip into sterile gowns and gloves. This scrubbing must precede that of the doctors, since the nurse will be expected to assist them in their scrubbing and gowning. The first patients are in the corridor or preparation room where they have been wheeled by an orderly, and they are already in a semiconscious state from sedatives.

With the arrival of surgeons on the scene, the tempo of preparation increases. Nurses are now untying the sterile bundles and spreading instruments out for instant use. Usually orderlies and the charge nurse

THE OPERATING ROOM

are checking lights, suction hoses, etc. The anesthetist is setting up his tanks and dials at the head of the operating table. Internes and their more advanced colleagues, the surgical residents, are ordinarily scrubbing before the operating surgeon appears. Much joking and chatter occurs between these younger doctors and the nurses. When the operating surgeon, an older and more dignified surgeon, starts to scrub, the tone of levity may decrease markedly. His appearance signals an even more alert and faster level of preparation on the part of other members of the operating team. The nurses assist the doctors in dressing for surgery; they hold gowns ready for them to step into when scrubbed, and when the gowns are on they tie them securely. They hold rubber gloves so that the doctors can put them on more easily. At this stage, before the incision has even been made, the motif of watchful cooperation has been established between nurses and doctors in the process of gowning.

Now the patient has been wheeled into the room and the anesthetist is busily caring for him, making him comfortable and applying anesthetic. [The anesthetist is the patient's direct "companion" in this venture, the person who reassuringly sedates him and establishes a close personal connection.] In a difficult case, the surgeon has perhaps previously consulted a colleague about the technique he plans to use and what conditions he expects to find. As the moment of cutting draws nearer, however, he is "on his own" as the captain of the team; his lonely responsibility is mitigated by the presence of younger doctors and nurses, but he must be the key decision-maker.

At the signal from the anesthetist that the patient has reached a proper depth of unconsciousness, the surgeon makes his first incision. [The patient has already been draped and painted by the cooperation of house staff and nurses, under the surgeon's direction.] Immediately, by spoken word or conventional hand signals, the surgeon calls on the nurse for sponges and instruments; the young doctors assisting at the operation are brought into play to hold retractors and clamps which staunch the flow of blood and keep visibility good in the operative field. At each stage in events, the surgeon consults the anesthetist to keep check on the patient's condition. Some portions of the operation may actually be performed by the surgeon's assistants, although he is always in close supervision and handles the critical moves himself. It is a mark of status to be allowed to work in the operative field, and actual surgery is done only by well-trained resident doctors. Nevertheless, the familiarity gained by simply holding the wound open for the surgeon is a vital part of the young interne's experience.

There are two parallel status lines at work in the room. The surgeon passes on commands to the senior resident, who in turn passes them to junior residents and internes. The scrub nurse likewise initiates action

for the circulating nurse and any students present. These chains of authority are crisscrossed by orders from the surgeon to the scrub nurse, and from any doctor to any of the nurses; however, action is seldom or never initiated in reverse. Nurses do not issue orders to any doctors and the lower echelons rarely direct the activities of the higher.

The operating surgeon, after finishing his major task, consults the anesthetist again with respect to the patient's general condition and the length of time required to close the wound. As the closing progresses, there is a visible relaxation of tension and vigilance; joking becomes more frequent, and the pace of work more leisurely. Before a stitch can be taken, however, the nurses must count the sponges used in the operation, as a safeguard against leaving foreign objects in the patient's body. Here, at least, the nurses do initiate action, since the surgeon waits for their assurance that the sponge count is correct.

During the sewing-up phase, the junior members of the surgical team usually take a more prominent role than they have in earlier stages. Often the chief surgeon will remove his gloves and stand around chatting, or even leave the room entirely. The resident is left in charge, and he and the internes proceed to apply the finishing touches. After all the sutures are in place, the anesthetist takes charge of dressing the patient and moving him from the table to a cart which will return him to his bed. In this he is assisted by nurses and usually an orderly. Sometimes the junior doctors will help out, but the chief surgeon is not engaged in this phase.

At length the patient, anesthetist, and doctors have left the room. The nurses are last to leave, as they are first to arrive. They pick up the doctors' discarded gowns and gloves, and prepare the room for the next case. The whole process, requiring from thirty minutes to six or more hours, has included a large cast of characters exhibiting much communication. Yet they are so familiar with their jobs that the number of spoken words may have been slight.

A marvelous example of outstanding team work has taken place. Although innumerable orders have been precisely responded to, most of them have flowed from the dictates of the patient's presence and condition. In a very real sense, few of the directives issued during surgery are arbitrary decisions on the surgeon's part. Rather, in the last analysis, the patient's needs have been the controlling element in the entire situation. Thus the person who seems to have been least capable of exerting authority—the supine, unconscious "object"—has in fact assumed the star role and preponderant influence on the course of the drama.

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Before aseptic surgery had replaced the antiseptic sprays of Lister, a noted surgeon used to pause before the operation and intone, "Brethren, let us spray." This irreverent remark typifies an important aspect of life in the surgery; where the job to be done is intrinsically abnormal and fraught with anxieties, the atmosphere is deliberately made as mundane and casual as possible. In this most serious of situations, efforts are made to keep the psychological climate prosaically normal. Energies must be mobilized for the work itself, not allowed to drain off in unproductive fear and anxiety. While operating rooms are not places of levity, and *Ars Chirurgica* advises the surgeon to be "fearful in dangerous things," the pattern of joking and small talk is perhaps the most striking feature of surgery to the outsider. There is drama, but only a fraction of total operating time looks anything like the Hollywood stereotype of tight-lipped tenseness and mute solemnity. The self-consciousness which one would expect to characterize a person invading another's body, and literally "holding a life in his hands," is for the most part dispelled by technical considerations; a job must be done, a careful, exacting task, and this is the focus of energy and intellect. Operating rooms, then, are workmanlike. The first impression dispels any thought of "constant crisis."

All operating rooms have some characteristics in common. They also fall into certain recognizable types according to major features, such as the kind of operation in progress. Yet each is in some ways unique.

A. Features Common to All Operating Rooms

1. Drama, Excitement, Intensity and Air of Importance

Surgery is so obviously worth-while and effective that it may be trite to comment on its importance. Yet there are many other aspects of medicine, equally vital, which lack its dramatic emphasis. In the operating room, there can be no doubt that what is being done is dangerous and vital. Because we all share a belief in the importance of the body, because it is a basic part of the human being's security, any drastic manipulation (such as cutting) is dramatically significant. Furthermore, the power to enter and change the body¹ imposes im-

¹ It has been remarked by many observers that in some sense the body on the table is no longer a human being in his fullest significance. The "person" becomes an "object" so that a complete emotional response to him is no longer necessary or possible. As the

mense responsibility on the part of the surgeon and creates an atmosphere of awe. The operating room is dramatic, even though it does not resemble the movie version. Each operation is a problem, a challenge, whose course can be plotted but not thoroughly predicted and which will have far-reaching consequences for the patient.

As one graduate nurse expressed it:

Down here you have the patient at the most critical time of his life and you know by the time he leaves the operating room what his chances are. You feel as if you are really important in his life. You're only with him a little while, but still it's the crucial time so far as he is concerned.

We have stressed the mundane aspects of the operating room, and pointed out the joking air which is often found. There is much talk of fishing trips and bridge and much mutual banter. This reduces tension, but cannot abolish it. A recurrent sign of tension is the tendency toward quick flareups of "temperament" or irritated and antagonistic remarks. An example of this tension is found in the recording of part of an operation by an observer seated in the gallery:

At this point, we have an interesting piece of interaction between the scrub nurse and Dr. M. The nurse hands him one swab, retaining another in her hand. He takes the swab as she hands it to him, and throws it angrily on the floor on the other side of the operating table. He asks, "Is this phenol?" (referring to the swab left in her other hand). The nurse replies (pointing disgustedly to the floor), "That one was phenol. This one is alcohol." Dr. M., "When I called for phenol twenty minutes ago, I *meant* phenol. I've got to swab that whole end off. Now get me some phenol." The nurse then fills a small cup with phenol and hands it to Dr. M. with a swab. This procedure he accepts.

chief surgeon once remarked to an observer seated in the gallery of the operating room, "This is a man; just wait; we'll put him back together again and you'll see."

A Nobel Prize poet has also commented on the patient as object:

Or, take a surgical operation.
In consultation with the doctor and the surgeon,
In going to bed in the nursing home,
In talking to the matron, you are still the subject.
The centre of reality. But, stretched on the table,
You are a piece of furniture in a repair shop
For those who surround you, the masked actors;
All there is of you is your body
And the "you" is withdrawn.

—T. S. Eliot, *The Cocktail Party*

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Dr. M. is now under great tension. It shows. His remarks become more brusque, irritated, profane. When the nurses have trouble getting a hose fixed up, he says, "Let's get going here. It takes twenty minutes to do a thing and there is one way to do it right!" The nurses begin to count sponges in a fairly loud voice. Dr. M. shouts to them, "Stop counting sponges! Don't do anything until I stop this bleeder." A moment later he shouts at Y (the assistant resident) "Pull back those fingers. Let's see this thing!"

2. *Emphasis on Teamwork and Cooperation*

Every operation is a *cooperation*. In surgery, no one can "go it alone." Each person is dependent on many others and the patient is of course dependent on all. So necessary is teamwork in the nature of the job, that individuals who are personally antagonistic often act in concert during the course of surgery.² The members of an operating team are so close-knit and understand the task so thoroughly that verbal signals are often unnecessary. A language of gesture is developed whose meanings are crystal-clear to persons following the operation intently. Perhaps the outstanding examples of intuitive cooperation occur in these pairs of team members:

surgeon-nurse

surgeon-anesthetist

surgeon-assistant surgeon

To the nurse, the intimate comprehension of the surgeon's technique, and his recognition of her competence, may become a prime reward of her job. That both nurse and surgeon recognize the desirability of a close harmony is illustrated in their own comments:

Morale is high in the operating room because there is a team spirit. The finest point in the nurse's life comes when she is finally taken in, and fully accepted as a member of the team. On a certain day, everything changes. There is almost a clean break with the past . . . the surgeon will recognize you and call you by name. A kind of emotional block is broken, and you know you are accepted. Any nurse feels very wonderful about this. The main reward for doing operating room nursing lies in a special relationship with the surgeon.

—An OR nurse

² In this, the operating team is like a jazz band or baseball club. Legend has it that the members of the famous double-play combination of Tinker to Evers to Chance did not speak off the field for many years.

Both instruments and nurses have to be worked with for a couple of years before you know them. If she (nodding at nurse) stayed with the same guy for two years, she would do everything before he even asked for it.³

—A senior resident

It is obvious that the surgeon and anesthetist must work together. The depth of anesthesia needed depends on the type of operation and the various stages in its progress, while the surgeon must be kept informed of changes in his patient's condition.

We then got into a discussion of how the anesthetist works. Dr. D. described as the most important, perhaps, a close cooperation with the operating surgeon. He said it is desirable that the anesthetist know the surgeon well, know his technique and be able to cooperate with him almost automatically.

—An anesthetist

3. *Technical Criteria and "The Religion of Competence"*

Efficiency and expertness are stressed in all operating rooms. This is due in part to the complicated nature of surgical work and it rests on an exacting knowledge of many factors. Unpleasant personal characteristics are often overlooked if competence is high enough. The irascible surgeon who is nevertheless highly respected for his skill is almost a legend. Colleagues and nurses judge doctors according to the mastery they exhibit.

The importance of cleanliness also emphasizes efficiency. The ritual connected with asepsis imposes a precision which is carried over to the nonsterile portions of technique. The surgical job is so demanding of precision that it sets a standard of mechanical perfection for all related jobs; because surgery must be orderly, the tasks that facilitate it must also be orderly. A "neat job," then, can describe everything from a virtuoso performance by a heart surgeon to the measured folding of towels by a nurses' aide.

In the surgery, all tasks are "obvious" and can be quickly judged by ideal criteria; nowhere is the American talent for, and admiration of, "know-how" more clearly shown. Precise technique is necessary to good surgery, yet possibly this emphasis also has a subsidiary function. It keeps the hands and mind busy on detail in a setting where

³ It should be remarked that this comment not only stresses the importance of intimacy and experience in teamwork, but also unconsciously expresses the sharp prestige differences by comparing the nurse with an "instrument" of the doctor's.

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excess imagination or sensitivity might interfere with the psychological boldness required.

4. *The Surgeon's Authority*

The surgeon is like the captain of a ship. He is ultimately responsible for everything that happens in the operating room.

—A chief of surgery

The surgeon's authority is unquestioned, because of three inter-related factors. First, there is the right relation between authority and responsibility; a person held to account for something must be in a position to affect the process by which it comes about. Great responsibility demands great grants of power. Second, the surgeon is at the top of a hierarchy of skill. He is not replaceable, and ideally he knows more about the job at hand than anyone else in the room. His competence confers authority upon him. Third, there is an aura of magic and reverence surrounding the surgeon.

Although authority is mitigated in several ways, it is a constant characteristic of the operating room. Relaxation of direct exercise of power may occur when long acquaintance and close work relations, especially those between doctor and nurse, lessen the third factor. The surgeon's failure to meet standards of competence weakens respect and leads to implicit resistance to his authority (or, rarely, transgression). At the least, the surgeon's overpowering position is almost certain to produce an undercurrent of resentment among the lower status members of the team. This is illustrated in the exasperated aphorism of an operating room nurse:

Nurses spend half their lives waiting on doctors, and the other half waiting *for* them.

5. *Physical and Psychological Isolation from the Rest of the Hospital*

To maintain asepsis and facilitate work flow, the operating suite is always separated from the hospital as a whole. It has its own floor or part of a floor and patients are taken to surgery and brought back to their beds by orderlies. Other hospital personnel rarely visit it. Casual visiting is prohibited, since nonessential onlookers tend to disrupt the precision of work and increase the danger of infection.⁴

⁴ The separate, confined spatial arrangement of the surgery may in some cases contribute to the surgeon's feeling of tension. He, the captain, is alone with the heavy

This isolation of the operating room means that to other employees it is strange and forbidding. They are on the "outside" and apt to be both curious and in awe about what occurs in the sanctum.

Conversely, the surgical staff, from doctors to maids, develop a strong feeling of camaraderie. They recognize their status and role as a special group. Their world is the operating room, not the hospital. This results in great warmth and cohesion, and the sharing of many values.

B. Types of Operating Room

There are a number of types of operating rooms which share secondary characteristics, which modify and supplement but do not drastically change the conditions noted above.

1. *The Extent of Teaching Carried On*

Operating rooms vary from those with no personnel in training to those that train student nurses, internes and residents. Where there are students, part of everyone's energy must go into teaching. A spirit of questioning and striving is kept alive by the presence of students. Surgeons, nurses, and surgical techniques have little chance of survival unless they keep up to date and competent.

Methods and attitudes undergo constant changes as the operating room keeps pace with medical science. The surgery evaluates its work against high standards. The stress on competence is heightened because every case is a model for the learners.

Division of labor is greater in teaching hospitals. More hands are available and there is a constant effort to split off suitable practice tasks to give the student experience. Both the nurses and doctors gain in competence by following a series of stages. Nurses progress from circulating duties to those of scrub nurse, from easy to hard cases. Internes and residents progress from holding retractors and suturing incisions to the actual work of the operating surgeon.

With a great division of labor, it is more difficult to achieve coordination of all the parts. Planning is essential and interpersonal, relations

responsibility of a difficult job. In one hospital where the door leading to the hospital corridor remained closed, but the scrub room entrance always open, the latter provided easy access for interested colleagues. Fellow surgeons would drop into the open door of the scrub room for a casual chat or consultation. Numerous observations demonstrated convincingly that certain elements of support were derived from this situation.

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take on added significance as more people are involved. Morale and skill must be high to insure smooth functioning.

Differences in prestige are multiplied in the teaching hospital. The ladder of status has many extra rungs for both the medical and nursing staffs. There are the distinctions between the scrub nurse and the circulating nurse, between the chief surgeon and the assistant surgeon, and the resident and interne. Students can increase in competence through clear and manageable stages and are not thrust suddenly into full professional responsibility, but the differences in prestige multiply opportunities for friction. Two operating room nurses describe the way behavior emphasizes status-laden differences:

They asked the question, "Who is the first person to leave the operating room after an operation?" And immediately answered it with, "The surgeon, of course." They said first the surgeon steps back from the table, takes off his gown and gloves and throws them in a heap on the floor and walks out of the room. Then the lesser fry close up the incision and then they leave, also stripping off their gowns and gloves and dropping them in a heap any place on the floor. They described how even the young resident will rip off a towel from the operating table, perhaps with several instruments on it, and just throw it to the floor while preparing the patient to go back downstairs and then the resident will wait for the nurse to untie his gown and stalk away. After everyone has gone, the nurse or nurses and the anesthetist are left to clean up the place and get the patient back downstairs.

Miss R. exclaimed, "After the great big doctors are all finished, who do you think moves the patient back onto the stretcher to take him downstairs? The nurses, of course." At this point Miss M. interjected, "Yes, that is what happens. They just walk out after shouting at you for two solid hours."

When students are present, each stage of the operation will be carefully scrutinized and explained. Although not all surgeons converse during the course of an operation, it is usual for the surgeon or his assistant or the senior resident to carry on a running commentary.

Students also introduce problems with respect to the amount of participation allowed them. In surgery, only one man can operate, whereas in the teaching of medicine the students can practice directly, make their own examinations, reach their own tentative diagnosis, and propose treatment for the criticism of the attending physician.

There is a story of a young interne which points up the dilemma. After a particularly impressive piece of surgery, the chief who had

performed the operation took the rest of the staff to the surgeons' lounge for a discussion. At length he turned to the interne, whose only duty at the operation had been to hold the retractor, and asked, "What did you learn from this operation, my boy?" The interne replied, "I think I have definitely established, sir, that the assistant resident has a terrible case of dandruff." Yet the chief of a neurological surgery department said that in his own experience the very gradual increase of responsibility was an excellent introduction to his specialty, and particularly that as a result he did not feel under too great pressure when, at length, he had full authority.

Problems of organizing the work in a nonteaching hospital are fewer. On the other hand, the team members lack the stimulus of being on exhibition before an eager, questioning group of students. It might also be pointed out that they have no scapegoats as ready at hand as students. Student nurses and internes appear to be legitimate targets for the impatience and anxieties of surgeons, residents, and nurses, who can vent their anger on a circulating nurse who trips over her own feet, or an interne who is woolgathering, without disrupting the rapport among the key team members.

2. The Difficulty of the Case in Progress

The relative seriousness of an operation determines many of the features of an operating room. With more difficult cases, as a rule, more personnel are involved, greater time is consumed, and a greater number of instruments are used. In these important ways chest operations in two different hospitals will be more alike than they are like a hemorrhoidectomy in either of them. While it is true that no two operations are ever exactly alike, the major varieties show definite similarities.

In a fairly easy case, the atmosphere of the room tends to be rather relaxed and is less demanding of strict attentiveness on the part of all concerned. The lowered tension results in less friction, but though there is less pressure there is also less excitement and feeling of importance, and there may be complaints that the work is dull and routine, that the challenge is not great enough to hold one's interest at a high sustained level. Precise coordination is also less difficult in a minor operation because fewer people are involved.

In the teaching hospital minor operations give an opportunity for the student to advance in responsibility. A surgical resident may be given a vein ligation as his first solo operation, or a student nurse may

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serve as a scrub nurse in the same operation. It is not true that these cases are taken casually, but they do allow a greater margin of error and seldom require split-second timing.

Since minor cases are usually short, they are less fatiguing. In a long exacting surgical effort, physical exhaustion may cause outbursts of temper; mistakes are less well tolerated toward the close of a lengthy job. Often a long case will involve shifts of personnel, especially nurses, and make tight coordination more difficult. Surgical personnel need physical endurance to meet the exacting demands of six or even eight hours of consecutive work. A noted surgeon once spoke of the possession of "good legs" as one of the qualities of a competent surgeon. There are undoubtedly other ways in which operating rooms could be classified (for instance, whether the surgical staff is open or closed), but these two characteristics, the extent of teaching and the nature of the operation, appear to be the most significant ones.

C. Unique Features in Operating Rooms

The unique quality of each operating room and of each operation seems to be due principally to three factors:

1. The personality of the surgeon
2. The personality of the nurse
3. The creative course of surgery itself

Some features of the personality of nurses and surgeons, such as those resulting from tension and fatigue, or from formal lines of status and authority, have already been discussed. There is some justification for the stereotypes of the irascible surgeon and the snippy nurse, but there are a host of actions, attitudes, and traits which make each individual in the surgery unique and modify the behavior which seems to be determined by the situation. An illustration of the influence of the surgeon's personal tastes is variation in the amount of talking and joking during the operation:

An operating room takes its tone from the personality and attitudes of the surgeon. It is not a joking place if the surgeon does not make jokes, and not a talking place if the surgeon does not like to talk while operating. [The nurse described several different staff members and their variations in operating room leadership and atmosphere. She said that Dr. T's operating room was always very friendly and filled with witty exchanges, while Dr. H's, although friendly, was strictly business.] One distinguished surgeon allows no talking whatsoever in his room, while

another is so jovial that he always remarks during an operation that he considers himself very lucky to have been given the very best nurses available for his operation.

—Interview with a clinical instructor (a graduate nurse)

Nurses may be impersonal or warmly involved, although they usually follow the surgeon's lead. When a nurse and surgeon are extremely well acquainted, and have between them the bond of countless shared experiences, their mutual personality adjustment may enhance greatly the technical efficiency of the team.

Surgery takes a different course each time it is performed, for the bodies of patients are by no means uniform. But the truly individual character of some operations stems from the creative element in new types of surgery. Perhaps a maneuver is being performed for the first time; perhaps the operation is exploratory and uncovers an unexpected cancer; perhaps a dramatic turn of events provokes an unanticipated crisis. In any event, something has been added to routine and the operating room acquires a distinct spirit of excitement and discovery. In surgery, as in any other creative activity, there are novel aspects which cannot be rigidly classified. Part of the peculiar charm of the operating room lies in its creativity, the fact that routine may always be upset. If there were no possibility for innovation and inspiration, if surgery were really "routine," it is doubtful that it would appeal to the caliber of persons who are attracted to the operating room team.

CHAPTER 18

SOME ASPECTS OF AN OUTPATIENT CLINIC

Introduction

THE OUTPATIENT CLINIC and emergency surgery are points at which hospital and community meet in their most dramatic, intense form. With no private physician to act as an intermediary, patients and hospital staff are thrust together in a variety of situations ranging from critical accidents to routine medication for chronic ills. The immediacy of these contacts generates behavior at all levels of human warmth, including the pathetic gratefulness of the individual who has found a haven and the brusque impersonality of the person shopping for a service. In serving outpatients the hospital has certain advantages not found in its relations with inpatients; the care is, if not free, less expensive to the patient so that he may often be expected to show gratitude and compliance, and housekeeping or hotel chores are minimized. However, there is also, psychologically speaking, one great disadvantage for the hospital staff. This is the loss of leverage which follows from the patient's independence of the hospital system. The client does not stay, does not give up the clothing which lends him individuality, in short fails to become a fully adjusted patient. He brushes against the organization but never becomes a real part of it, while the inpatient enters the system more or less fully as soon as he occupies a bed.

Outpatient clinics vary a great deal from region to region, and even from one local institution to another in the same city. In many Eastern

areas the clinic preserves much of the traditional character of the hospital as a charitable service for the most unfortunate segment of the population. While small fees may be charged, they are often so nominal that they emphasize the clinic patient's dependency rather than minimize it. In the West, where hospitals have tended historically to serve the entire community, the clinic also is used by a much wider segment of the population and it charges fees more comparable to those charged by private practitioners.

The clinics we have observed are nearer the charitable type. What we found is therefore far from typical of outpatient services everywhere, but it is included since it clarifies some of the factors which influence the human organization of the hospital.

Our most intensive clinic study was in a metropolitan hospital; patients represented many types of nationality and personality, although almost all were from low-income groups. The hospital was proud of the clinic, and its long history represented a very substantial contribution to community health. Altruistic motives were reinforced by the need the clinic met in providing training for medical students. There was an especially strong effort to maintain personal relationships with the patients, an effort which seemed largely successful as the result of alert performance by staff members from physicians to clerks. Yet it must be stressed that the doctor-patient relationship is a problem in the outpatient clinic, because the goal of serving large numbers rapidly and inexpensively naturally conflicts with the goal of fostering an intimate therapeutic bond.

Clinic work of the sort we shall discuss must be distinguished from emergency surgery. Although emergency cases are indeed outpatients, their care obviously differs from that extended on a regular, scheduled basis in the clinic. The emergency room probably requires a unique nursing skill, and certainly attracts a more varied economic range of patients. Further, the relationship to patients is by definition one of extreme urgency; the doctor is concerned about an immediate problem, stitching a wound or ministering to shock, rather than a course of planned treatment. Yet the parallels must not be overlooked. There is the direct, frontal meeting between patient and staff noted earlier in both situations, and a certain similarity in the nurse's role might be pointed out. The nurse plays a larger than usual part, including more of the doctor's function, in both kinds of outpatient facility. In the surgery she must care for the sufferer until a doctor can be summoned. In the clinic she may herself give routine treatments, and she usually has

to guide or comfort the patient before and after his necessarily brief session with the doctor.

The Work of the Outpatient Clinic

A full-fledged outpatient department is really the hospital in miniature. The patients are not fed or housed, and major operations are not performed, but virtually every other hospital function is carried out. Despite the fact that the clinic draws constantly on its parent institution for special services, its very comprehensive offering of care tends to promote among its staff a sense of independence from the total system. This feeling of being in a self-contained world is heightened by physical separation, for the clinic usually has a wing or floor, or sometimes a separate building of its own. Like the laboratories and the social service department, the clinic setting stimulates keen ingroup sentiments, a mood of exclusiveness or special mission which bolsters internal morale. Also like the other rather independent groups, the outpatient staff may pay a price for inner cohesion in the form of indifferent or antagonistic relations with its sister departments. One striking instance of conflict occurred in a general hospital where the executive in charge of the clinic resented what she viewed as the "interference" of the social service department in counseling outpatients. Obviously, the trained social worker has a very legitimate job in this area, but her performance of that job, however competent it might have been, did break into the exclusive, special sense of responsibility the clinic director held toward her patients.

Another point often at issue in the dealings between the clinic and the total hospital is the degree of freedom the clinic is to enjoy. We have noted that in providing an extremely broad range of services the clinic tends to duplicate the hospital on a smaller scale. It may have its own budget, which accentuates its independence. Yet outpatient work is a constant drain on hospital resources. In older Eastern institutions, the clinic produces a chronic deficit which the hospital must meet. One should expect, then, that the relations between this department and the administrator will be colored by the financial problem. Policy must naturally follow the purse, at least to the extent that the independence of the clinic is limited by the administrator's attitude toward the deficit. Even in an observed case in which the clinic director and the administrator enjoyed a congenial understanding based on long cooperative experience, clinic policy was inevitably oriented to justifying the size of the deficit. The outpatient clinic is

therefore limited in its autonomy by financial considerations as well as by its need for cooperation with other hospital elements such as the medical staff, pharmacy, and social service department.

The general flow of work is ordered in a definite pattern, yet varies greatly, as medical work must, according to the volume and type of cases. It is perhaps more nearly a routine than one finds in most sections of the hospital, but the exact timing of patients is unpredictable and long hours of waiting are faced by nearly all clients. On a particular service, for instance the arthritis clinic, the number of patients fluctuates enormously from day to day.

The patient is first met by a clerk or, in some clinics, a nurse who serves as "gatekeeper" in a manner quite similar to the admissions office in the larger hospital. The first admitting interview is designed to gain basic identifying information; in a heavily subsidized clinic, it may give special attention to the patient's financial background, since his eligibility for care must be demonstrated. He is then referred to a physician, who assigns him to the appropriate service or services for his illness. The critical importance of this diagnostic step is obvious, for once the patient begins to attend his assigned service his visits tend to become increasingly routine. Here he acquires a chart and proceeds to the service; the chart will follow him throughout his career as a clinic patient. When he reaches the service, a nurse begins her intensive and extensive relations with him. On succeeding visits he will take his chart from the clerk directly to the nurse, and she will guide him before and after his session with the doctor.

Over the whole network of admission, referral, treatment and return for further treatment, the clinic staff engages in a task, a watchfulness, that exceeds purely medical considerations. The outpatient often needs guidance and solace as much or more than he needs medication. Every staff member is involved in something like psychological therapy, educating the patient to deal with his illness and to use the clinic facilities intelligently. The outpatient in a free or nominal-cost clinic is unlikely to be a confident, assured human being, since the crippling effects of poverty have been added to the crippling effects of illness.

The Patients

Except for prenatal cases the patients tend to be elderly people who eke out a marginal existence on pensions and social security, or older workers whose illness has forced them to stop or limit their activities. In addition, there are a certain number of emergency clients and

younger people who are enervated by chronic disease. But the bulk of the patients are over fifty years of age and a large percentage face life virtually alone.

The outpatient is likely to be facing a rather bleak world outside the clinic. He is burdened by his illness, the emptiness of his life, and the unescapable realization that he is an object of charity. He is generally passive, somewhat bitter, somewhat confused. Not all patients are thus bowed down, but the exceptions are so rare that they cause much comment by clinic personnel. The more spirited patients may become pets of the staff, or, since they do not behave according to expectations, those who show too sturdy an independence may become scapegoats. By not "acting like a clinic patient" the active and forthright individual may irritate nurses and doctors who are used to treating submissive people.

Those patients who are older, and whose lives outside the hospital are rather grim, may look upon clinic day as a social event. One man showed up at his scheduled clinic at 8:00 in the morning in a very heavy snowfall when traffic was so crippled that no staff member had yet arrived. Another elderly woman insisted on hobbling into the arthritis clinic each Wednesday despite the fact that arrangements had been made to have her injections given at home by a visiting nurse. She explained that this clinic was her only opportunity to get out of the house and talk to people; she would not sacrifice such a pleasant activity.

Outpatients, in their search for recognition and warm human relationships, may lean on one another as well as on the clinic staff. They enjoy talking about themselves and their symptoms. Some are perhaps more important as personalities here than they are outside the hospital. The corrosive loneliness that often disfigures the inhabitants of furnished rooms is alleviated by informal conversation during the hours of waiting. The clinic's hard bare benches reveal what the humor in the trite phrase conceals: "Let me tell you about *my* operation" is a request for shared experience and a plea for recognition as a distinct person. Of course not every patient indulges in casual conversation; there are the disaffected and cantankerous who try to dominate the talk in explosive diatribes, and the frightened, pain-ridden figures who shrink from contact.

The Staff

1. *The Office Worker*

The four principal groups in the clinic organization are office workers, nurses, doctors, and medical social workers. The office workers act as receptionists and keep records. Records are extremely important in the outpatient clinic since they insure a continuity and consistency in treatment, which might otherwise be lost in the fast-paced routines. These workers also compile statistical reports for the hospital administration, but their work brings them into much closer contact with patients than that of most office workers in the rest of the hospital. They take the initial basic history; they locate the patient's chart when he comes back for later appointments, trace down laboratory tests, and arrange for his admission if he requires inpatient care; and they may guide the patient personally to the appropriate location or push him in a wheel chair.

2. *The Nurses*

The nurses have a wider range of functions and responsibilities than nurses on other hospital floors. On the one hand, they encounter more extramedical details (for instance, listening to a patient's family problems) and on the other are entrusted with more responsibility for medical care. The patient volume and the limited time of the physician require that much responsibility which is usually the doctor's be delegated to nurses. Like the office personnel they tend to identify with the department and to consider themselves distinct from the total organization, although authority and salary both flow from the regular hospital administration. They also appear to think of themselves as an elite subgroup, partly because of enlarged responsibility and partly because they feel that in the clinic the nurse enjoys a more informal and intimate bond with the doctor.

3. *The Doctors*

The only doctors at the scene of our major study who do not offer their services free are a clinical director and a member of the resident house staff. These are the first physicians to examine the patient and they refer him to one or another of the clinic facilities on the basis of their diagnosis.

The volunteer physicians are members of the hospital's attending

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staff and devote one or two mornings a week to the clinic. An individual doctor may see from one to over a dozen patients, and consultations vary greatly in length depending on symptoms and patient volume. Despite the pressures of time, an effort is made to approximate the doctor-patient relationship; private consulting rooms are used and no formal time allowance is imposed. The nurses handle the scheduling of patients but planning is difficult because the attending physicians don't adhere to a strict schedule.

Outpatients give the doctor a richly diversified range of cases for his professional experience, and this is the principal compensation for time spent at the clinic.

A young doctor just beginning his private practice said:

I get a variety here; if I'm not interested in a case, I can refer it on to someone else. I see more cardiac cases here in a week than I would in a year of private practice. Also it's stimulating to have specialists around, to exchange points of view. The clinic is a good place for "curb-stone consultations."

Since the physician spends only a short time at the clinic and has many other professional interests, he is probably the least integrated into the clinical staff. Yet he shares the camaraderie of the autonomous group and is spoken of by nurses and clerks as "one of *our* doctors." Although his attendance is irregular and he may sometimes lose interest in the routine cases, he gives a good deal of devotion, effort, and skill to the outpatients and the other members of the staff.

4. *The Medical Social Workers*

Medical social workers act to facilitate the direct efforts of doctor and nurse. Very often the outpatient is unable to care for himself properly without expert aid. The poor living conditions and lack of basic hygienic knowledge which contribute to the illness itself in the case of many outpatients may also thwart the prescribed cure. Ignorance and economic distress combine to form an extremely difficult set of problems. Most of all, the ill person needs general guidance, much like that which the more fortunate get from a private doctor. The outpatient must be told where to go for orthopedic shoes at a low price, how his diet may be improved by free milk or oranges from the city welfare department, what the terminology used by the physician really means for his future behavior.

A dramatic illustration of the social worker's clinic role is found

in an incident involving a teen-age girl and a busy resident physician. The girl, a slow-spoken, confused person, had been given numerous tests in an attempt to diagnose her nausea and gain in weight. The resident had conclusive evidence that she was pregnant, but she had repeatedly denied this possibility. She feared her mother's anger. At length, the resident felt he had to break her story and force mother and girl to accept the fact of her pregnancy. In a stormy interview, the girl confessed; she did not know the father well, and could not expect him to marry her. The resident offered to tell the sobbing girl's mother, but she somehow gathered strength and stumbled from his office to relay the news herself. Immediately the doctor telephoned a social worker, explained the case, and urged her to see mother and daughter without delay. This resident, however conscientious, could not follow the situation beyond his office door; a dozen other patients waited for diagnosis. It was the social worker's task to step in and guide two shaken personalities, to arrange for prenatal clinic and delivery, to advise on the myriad details of the complex pattern to which she had been introduced by the resident's brief message, "We've got another O.W. [Out-of-Wedlock] down here for you."

5. *The Clinic Director*

The many people who contribute to outpatient care must be coordinated into a working unit; hours and types of treatment must be staggered to control the flood of patients; the clinic must be represented in its relations with the hospital administration and other departments. All these, in addition to the complicated financial management, lie in the province of the clinic director. This executive, who in one hospital is a former nurse and social worker of solid experience, fills a varied set of roles. Her abilities ideally range from business acumen in the field of cost accounting and regulation of patient fees, to supervisory talents, to sympathetic skill in the guidance of dependent patients.

Certain Typical Relationships

1. *Office Worker-Patient*

When the patient first comes into the clinic, a girl from the office takes a brief history and instructs him to wait for an examination. A newcomer is usually confused and rather nervous, but is immediately caught up in the process by giving the bare details of his history. In this public place, with many onlookers, he is asked his age, marital

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status, and financial condition. The responses are halting and diffident in tone; and the clerk, although she speaks of history-taking as her chief satisfaction in work, shares the patient's embarrassment. Often he wants to launch into a description of his malady, but the clerk tries to quell this impulse by asking him to tell his full story to the doctor. Despite the patient's passivity, which sometimes approaches numbed unawareness, the relationship has some positive elements. The patient has a listener who responds by a nod or smile giving him reassurance and sympathy. Her relationship to the patient is decidedly a part of the therapy. It may be less than ideal because of overassertiveness or negative attitudes on the part of the patient. And the clerk may be unable to hide her irritation at the patient's ignorance or unsavory appearance, or his display of too firm a spirit. Occasionally she comments to a fellow worker on the "stupidity" or "craziness" of a patient. In general, however, this first contact is friendly and reassuring.

2. Nurse-Patient

After an initial diagnosis, the patient is seen by the nurse and most of his subsequent interaction is with her. On many routine return visits, he does not see the doctor and the nurse gives him his treatments in accordance with written medical orders. The nurse knows the patient better than anyone else in the clinic, and the bond between the two is likely to be warm and close. Because of the very intimacy of the relationship, when hostilities arise they are most often expressed toward the nurse or by her.

Nurses will describe at length their emotionally toned relations with favorite patients. At holidays many patients bring them gifts, usually quite small, which are meaningful to both. One elderly lady presented each nurse with a tissue-wrapped dime; another passed out five-cent candy bars. This may at times be an attempt on the patient's part to curry favor or a wish to dominate the nurse in some small way by being for once the giver; but for the most part it expresses the genuinely friendly ties which develop.

The nurse gives more than medical care. In addition to general guidance and informal psychotherapy, she may assist in a variety of life's details. In one case, a nurse collected several dresses and a coat for a woman whose welfare allowance did not permit her to be well-clothed. This gracious act could not have occurred if the nurse had not been extremely well versed in the patient's history. Such knowledge is not unusual. Both nurses and clerks can give a succinct life

portrait of many patients, and these are a favorite topic of conversation among staff members. Though there may be an element of gossip and vicarious thrill in peering into other private worlds, it also indicates a very real involvement of the staff in patients' problems.

A conflict in attitudes toward outpatients which permeates the entire clinical staff is most obvious in the nurse. On the one hand she feels compassion for the underprivileged, and on the other hand a scorn for the weak and unsuccessful person which is reinforced by the widespread assumption in this country that poverty indicates moral turpitude. There is a persistent undercurrent of aggression against charity patients which is rarely allowed direct release but may take the form of harassing remarks to keep the patient in line or stories about abuses of welfare aid, such as the outpatient who arrives in a limousine or the one whose television set is so loud that it interferes with telephone calls. A certain amount of "bullying" by staff members is perhaps necessary or at least excusable, since these patients need guidance, and may need admonition, to care for themselves properly.

3. Doctor-Patient

The effort to make the doctor-patient relationship like that of private practice is not completely successful. The recognition that the patient is a charity case cannot be completely overcome. The pressure of time is greater than in most private practice; the doctor sees the patient for only a short time and at infrequent intervals. The patient spends more time waiting his turn than in physicians' private offices.

The patient in a clinic waiting room is passive, following directions meekly, and by the time he meets the doctor he is apt to be in a submissive state. His relationship with his doctor is also apt to be less personal than with a private physician because he is used as teaching material for medical students and internes. His symptoms, physical findings, and diagnosis may be discussed in his presence by a group, and he may be subject to repeated physical examinations by students. While this results in a more impersonal relationship and may be embarrassing or physically trying, it is at the same time a clear assurance to the patient that he is being given skilled attention and thought.

The outpatient usually appears to have a great faith in his physician, perhaps in part because of a paucity of medical knowledge. The lack of medical information frequently makes a great deal of explanation necessary. Since doctors are hurried, this responsibility often falls to the nurse or the social worker.

4. Nurse-Doctor

Nurses feel that the doctors in the clinic are more relaxed and approachable as human beings than elsewhere in the hospital. There is often a joking relationship, with doctors spinning tales of past cases, and mutual "kidding." They come to know each other very well and at times call each other by their first names. There is a team spirit which overrides status distinctions. The air of greater equality is enhanced by the nurse's increased responsibility. We saw no evidence of jealousy on the doctors' part of the nurses' larger duties. On the contrary, when a nurse was able to pass a tube down a patient's throat more deftly than the interne, the medical staff seemed to welcome and applaud her efforts.

The major strain in the relations between the two is over the doctor's attendance and promptness at the clinic. His tardiness keeps patients waiting for long periods; the nurses' work is increased since they must pacify impatient, troubled individuals. They can exert only informal pressure on physicians through innuendo and half-joking criticism. A clinic executive and former nurse exclaimed, "...if only the doctors would come on time; they could sleep or see private patients later in the day." A charge nurse said that a doctor who had been absent from that morning's clinic "was ashamed to look at me" in the coffee shop.¹

Summary

For the staff the outpatient clinic is a high-spirited place. Members are bound closely together by the demands of patient care. Their cohesiveness is strengthened by the semi-independence of the department and the sense that they are performing an extremely valuable job. They think of themselves as a unit, an autonomous going concern. Although patients tend to be submissive, they are a part of the human relations in the clinic. Their interaction with staff members sometimes produces uncommonly warm bonds. The "regulars" act like people who have come home, and their clinic visits may actually be more rewarding to them than many other aspects of their lives.

¹ Much of the difficulty stems from the fact that informal pressures among the doctors were insufficient to prod all of them into faithful or active clinic attendance. The medical director attributed it in part to the low salary and prestige of his own position. His prestige was less than that of a Chief of Service and his requests on attending physicians had less weight than the requests of a Chief of Service for ward attendance.

CHAPTER 19

THE LABORATORIES

Introduction ¹

THE OXFORD ENGLISH DICTIONARY defines a laboratory as a building set apart for experiments in natural science. One clue to the nature of hospital laboratories may be found in the phrase "a building set apart" for they are indeed isolated (if not literally in a separate building) and have a distinctive identity. They are located as a rule outside the main flow of traffic, often in the basement. Their work has increased so rapidly that hospitals have found it difficult to keep up with their need for space. Overcrowding and inadequate room for storing equipment appear to be universal problems.

The spatial remoteness of the laboratory is matched to some extent by an isolation from organization of the rest of the hospital. It is true that laboratory research has been basic for a century and more in the development of modern scientific medicine, but the extensive application of laboratory methods directly to clinical problems has been relatively recent. In the larger hospitals with teaching and research functions, the laboratory for research purposes was well established before practicing physicians began to use clinical laboratory reports extensively for help in diagnosis. Such laboratories were able to take over clinical tasks and gradually expand their services with very little change in their relationships to the rest of the hospital.

¹ This chapter is primarily based on an intensive case study and analytical report on the laboratory of a large general hospital which was carried out by Mrs. Judith Seaver Shea. Her study was supplemented by less exhaustive ones in medium and small-sized hospitals.

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In smaller institutions, devoted entirely to the treatment of patients, the clinical laboratory came in often in part as a result of outside pressure. The place for it, both in the physical plant and in the organization structure, had to be found. New relationships had to be developed quickly if the laboratory were to serve its function. Acceptance by the older departments had to be won. In the smaller hospitals that we studied, this process is still going on.

Though the laboratory is recognized by many doctors as the very heart not only of medical advance but clinical practice, others feel that it is of very secondary importance. The laboratories which we studied differ very widely in their acceptance by the hospital, in the nature and amount of interaction between their workers and those of other departments, and in their internal relationships. On the basis of our limited studies, very few generalizations can be made. Laboratories, however, are so important both in patient care and in their effect on relations within the hospital that we feel that we should report the contrasting patterns we observed in spite of the few cases involved.

The Function of the Laboratory

The hospital laboratory has a number of related functions. Its primary purpose is to provide data for the attending physician which he uses in arriving at a diagnosis, following the course of illness, and judging the results of treatment. In the second place its reports, especially on post-mortem examinations and on tissues removed in operations, serve as a quality control and the means whereby practicing physicians can measure and improve their clinical performance. In the third place, the laboratory is part of the safety organization of the hospital. It furnishes information essential for the control of infection and incipient epidemics through routine bacteriological tests and special investigations. Finally it is often engaged in research, directed either to the development of improved techniques and new clinical tests or to basic investigations in pathology and physiology.

The laboratory performs a wide range of tests. The techniques employed are derived from many of the basic medical sciences—hematology, bacteriology, physiological chemistry, immunology, and gross and microscopic pathology. In the smaller hospitals, the tests are performed in a single laboratory under one director, but in larger ones there may be separate laboratories with specialized staffs each with its own medical director. Although the clinical tests have been developed from laboratory research in one or another of the basic medical

sciences, in order to perform them effectively the technician does not need a broad knowledge and understanding of the science from which it was derived. What he does need are skills derived from constant practice, conscientious precision, and mastery of an exact and often complicated routine. Conscientious precision is necessary not only for the patients' welfare but because laboratory work is a hazardous profession. Safety precautions are necessary and well observed, but the roll of "medical martyrs" who have lost their lives in laboratory pursuits is an honored one and reminds the workers that they are handling dangerous material.

The responsibility of the laboratory technician usually ends with his written report which is transmitted to the clinician. He does not even need to know what clinical use is made of it, although most laboratory workers have considerable interest in this. On the other hand, pathological diagnosis and research demand a very broad grasp not only of the basic medical sciences and their relationship to one another, but of clinical medicine and its relationship to the basic sciences. We therefore find in laboratories two quite different types of activity performed by people with very different training, the pathologist or medical director and the technicians.

The Director

The laboratory director is a highly trained specialist. He diagnoses the tissues removed in an operation or biopsy and conducts post-mortem examinations and makes post-mortem diagnoses. He is also responsible for the reports of his technicians, and for the training of new workers in the techniques of his laboratory, whether they come fresh to the field or have had previous experience elsewhere. He usually takes an active part in this training. Once he is satisfied with the accuracy and conscientiousness of the technician he does not supervise her work very actively but delegates responsibility to the chief technician. He also delegates to her the organization and assignment of work. However, when one of these workers comes across something unusual in what is otherwise a routine procedure, the director is at hand for advice and help. The responsibility for keeping abreast of new developments and introducing new examinations and new methods of performing old ones is largely his. Such changes very frequently involve purchasing new apparatus and acquainting the attending physicians with the uses of the new tests.

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Communication with the rest of the hospital, except for routine reports, also is very largely through the director. He represents the laboratory to the rest of the hospital but his outside contacts are usually rather infrequent. His dealings with the administrator are apt to involve requests for expenditures for new equipment, larger quarters, or salary increases for his workers. Until recently it was an unusual hospital administrator who was interested in or more than superficially informed about the technical problems and pursuits of the laboratory. He was usually dependent on the judgment of the attending staff for evaluating the laboratory director's competence.

The director's work does not often bring him into face-to-face relations with the other doctors. If he is engaged in research which calls for constant comparison between laboratory results and clinical progress of patients, he may have frequent conferences with attending physicians but many of the attending men are content to receive written reports and almost never make a visit to the laboratory.

Laboratory directors differ markedly in the zeal with which they present the needs of their workers to the administration and protect them from unnecessary pressures from other groups. Some are very actively concerned for the welfare of their workers, but others conform to the popular idea of the scientist so wrapped up in his research that he is oblivious not only to his own comfort but to those who work with him. One eminent pathologist remarked that he was unworried about the size and comfort of his quarters, so long as he had the proper testing equipment for certain fascinating investigations.

The Laboratory Technician

Medical technology is a growing field which has not yet become standardized. There is no single pattern of either recruitment or training. Within the profession itself there is still unclarity about requirements and certification, although the professional associations of laboratory workers are making constant efforts to build an orderly sequence of professional induction and to establish and raise standards. Most technicians are relatively young women. (A small minority are men.) A large proportion of them regard laboratory work as a short-term career. Like many other jobs, notably certain secretarial and clerical positions, that of the technician is filled by successive waves of girls whose primary goal is marriage, though the requirements of education and skill are somewhat higher than for secretarial work.

Reasons for Vocational Choice

We found wide variations among technicians in the nature of their work satisfactions and in the way they had decided upon their career. For the majority, laboratory work appeared to be a satisfying but not intensely interesting job. Many of these had had less satisfying experiences in one or more other vocations before getting into laboratory work. Mrs. Johnson was an example of this group.

Mrs. Johnson started out being a librarian and then she became dissatisfied because the position she had was in a small town where she said she could not live her own life. She felt that every step she made was watched by the people of the town and that she wanted more freedom than this. She said that she had always been interested in the sciences and had considered going into medical technology. She said that when she approached various doctors in the town most of them said that this would be foolish, that a person with her background should not go into medical technology work because the field did not require as much education as she had and did not give the prestige she should be receiving in accordance with her education and intelligence. However, one doctor in town did think that medical technology work was very important and encouraged her to go into it. He said that if she did she should definitely not work for a doctor in his office, but should get into a hospital where she could go ahead and do some more advanced work. At that time there were very few schools of medical technology and her choice seemed to be between Boynton and one of the New York City hospitals. The course at Boynton was only a year whereas in New York she would have to stay two years, so she went to Boynton.

A smaller number took up laboratory work as a second choice which appeared closely related to the career in nursing or medicine which had been their first enthusiasm and which they had had to give up because of financial or health problems. Miss Appely became a technician when she was not accepted for nurse's training.

You see, I always wanted to be a nurse. I went down to General to apply and made the mistake of admitting that I had had scarlet fever. The nurse there said, "What did that leave you with?" and like a dope I said, "Kidney trouble." Then she told me that they don't like to take girls who have kidney trouble, so I was out of luck. Somebody told me about the technician course up here and it sounded very interesting so I decided to try this. I am really more enthusiastic about this work than I could ever be about nursing. Maybe that's just an idea. I don't have any-

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thing against nursing. I just think I like this work better. It teaches you more things than nursing would. You go into a lot more and you get to see the patients just as much as the nurse does. We're up on the floor almost every day.

For Mr. Cole laboratory work was a substitute for a medical career:

Mr. Cole told me that he had a B.A. degree plus two years' training in medical school. After his second year in medical school, he had run out of cash; but before he got back to school, the Navy had got him and he served four years in the Navy and then he came back to this work and had taken a course as a medical technician and has his license. Cole told me that he is now married and has two children to support. For this reason he doesn't know if he is going on.

Among the technicians whom we interviewed, there were only a few for whom the work was the first vocational choice. Mr. Cantor appeared to be one of these:

As a matter of fact, our family doctor suggested that I come into it. I was unable to decide what to do. I wanted to go on in school but my parents weren't able to support me. I wanted to go to college for four years and then come into laboratory work. However, now that I am in it, I like it very much.

Satisfactions

The technicians whom we interviewed almost without exception were very happy in their jobs, though they seemed to differ considerably in the kind of satisfaction they got from them. For a relative few the work itself was intensely interesting. We talked to some laboratory workers who had a consuming scientific interest and for whom the work represented a lifelong career. These were generally the workers who were most active in the professional societies and most concerned with raising professional standards and achieving recognition for the professional status of the work. The chief technicians usually came from this group and their enthusiasm and concern with professional standards of competence contributed importantly to maintaining the quality of work in their laboratories. Where such a worker had an opportunity to assist in a research project, her satisfaction was increased.

For a considerable number of technicians, on the other hand, the job itself seems to offer less intrinsic satisfaction than those of many hospital workers. The work is not dramatic like surgery and in the

largest hospital which we studied the technicians have very little contact with patients. Their efforts are directed toward what seems to be an impersonal fragment. The work does call for precision in performing tests and reporting results, but does not provide the excitement of pursuing faint clues, fitting fragments of information into a coherent pattern and weighing conflicting evidence, which is an important reward both for the laboratory director and the practicing physician. For a large number of workers in the laboratory, the principal source of satisfaction appears to be the pleasant human relations which prevail there.

Laboratories are quiet places. While the work is exacting, it quickly becomes habitual and there is opportunity for free conversation during much of the working day. There is much mutual exchange of anecdote, outside interest and serious concern. Homogeneity in age and sex and the isolation from the rest of the hospital stimulate group feeling which is often so strong that it seems to isolate the technicians even during their off-duty hours. They tend to eat together as a group and to take their rest periods together. They reported very little social contact after hours with people from other parts of the hospital. In the large hospital where there were a number of separate specialized laboratories, these appeared isolated even from each other. There was surprisingly little social intercourse between workers in different laboratories. Though the student technician during her training rotated through all the laboratories, once she received a permanent assignment she usually became wholly identified with her own group, and the relationship which she had established in other laboratories tended to drop away.

The informality of the laboratories was mentioned very frequently as a source of satisfaction. Technicians often contrasted this with the formal etiquette demanded of nurses. They felt that nurses can't divorce their professional from their private lives, while technicians are their own masters when they leave the laboratory.

Well, nursing and this both have their appeals. Both have glamour, but I think you feel like your own boss in this, more than the girls do when nursing. You don't have such close supervision, you know what to do and you go ahead and do it. Nobody is telling you to clean your shoes and so forth.

Q. How is it with the technicians—do people keep after you at all? Is there any training in professional ethics and etiquette?

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Nothing has ever been said to me. When I first came here to be interviewed by Dr. Adams, he told us that we have to wear a white uniform and white shoes but that was all that anybody said.

A frequent observation of the technicians was "nobody is breathing down your neck."

The routine supervision of the laboratory is given to the chief technician. She usually attains her position from seniority and long experience rather than special training and comes from the relatively small group for whom laboratory work is a career. Her supervision is simple and unobtrusive. The routines are thoroughly established. Very little intervention is necessary and since the work to be done is clearly visible, the workers not infrequently divide it among themselves in an informal way. Status differences are at a minimum. The chief technician does much the same work as the other girls, though she may be called upon for help when difficulties arise. In the laboratories which we observed, informal relations and ignoring of latent status differences were extended to students in training, the secretaries, and the unskilled workers who wash the glassware.

Even though the work itself did not appear to be intrinsically of intense interest to a fairly large proportion of the laboratory workers, its importance to the welfare of patients and the vital contribution to the work of the attending physician were very obvious. The awareness that their work contributes to humanitarian service is a practically universal reward to the technicians, however diverse their interests may be in other respects. This satisfaction is allied to that which comes from association with the laboratory director. When he is a professional leader, his laboratory shares in his reflected prestige. The technicians whom we interviewed generally displayed a very genuine devotion to the attainments of their leaders and not infrequently a warm personal regard as well. This quotation from a laboratory secretary expresses the attitude which we frequently saw in the technicians. It also illustrates the close identification between the professional and nonprofessional workers in the laboratory.

I think he is a wonderful man myself, to tell you the truth. You know, he is only about thirty-seven years old. It's wonderful to work for a man that is on his way up. I think he is going to be a very important person someday. Well, you might know, he is already on his third textbook and one of his other textbooks, they're using it in the University of Texas. I happen to know that because a friend of mine was out there and told me so.

His teaching responsibilities also may strengthen the bonds between him and his workers.

Then Dr. Frankel gives us lectures. He is wonderful. He is really an excellent lecturer and I don't think it could be any clearer than it is when he is finished telling you about it. He will go into the finest details on anything you want to know. There really isn't any reason why you shouldn't understand it perfectly when he is finished and he is always very nice anyway, a wonderful person.

It might be supposed that the wide difference in background and training between the technicians and the laboratory director would be a source of friction, but he gives very little direct supervision and since he does not spend much time with the technologist they are not constantly reminded of status differences. They know that he is in his own office busy with things which bring prestige to the laboratory. When he does deal directly with the technicians it is frequently to help them with problems which have come up in their work. The tasks are related, but they are sufficiently distinct not to encourage feelings of rivalry. When the director is active in promoting the interest of his workers with other departments in the hospital, this naturally enhances their loyalty to him and their satisfaction on the job. But even when he appeared largely to let these problems go by default we found much evidence of pride in being associated with him. Perhaps the fact that he coincided with the stereotype of the other-worldly, devoted scientist compensated in part for the lack of intervention in their behalf.

Training

Though the professional associations have standards both for schooling prerequisite to entering a laboratory training school and for the content and length of professional training, there is still wide variation in actual practice. Some students enter training directly from high school, though most of them have had two years of college and many are college graduates. A few have masters' degrees. The training period varies from one to two years with a growing tendency toward the longer period. It also varies in its emphasis on theory but a large part of it consists of performing routine tests. There seems to be no other way to attain the almost automatic precision required. The student in training does a considerable part of the laboratory's work but also consumes a good deal of time of the experienced technicians and the laboratory director. The director is usually zealous about the standards

of training and insists on superior performance. One director described his weekly test sessions.

Each week they have a problem slide. They are urged to make careful inspections and write down the best possible answer, then we compare notes. The process has excitement and drama. The students feel they are in on big things. They are. Sometimes I am not entirely confident of the answer myself.

Differences in training might tend to split the technicians into those whose ability rests largely on long practical experience and those with more theoretical background. We saw less evidence of this in the laboratories than in some other groups in which training is changing from what has been essentially apprenticeship to greater emphasis on theory and formal schooling. Perhaps the fact that precision and speed, which are obviously very important for success, are achieved only by much practical experience and quickly lost without it, minimizes the conflict between theory and practice. The good relations which can exist between people with different training is shown in the following account:

Mrs. Watson is a younger woman than Mrs. Callahan, her superior. She is a registered technician with a master's degree in technology. She is not a registered nurse as is Mrs. Callahan. Mrs. Watson works half-time and Mrs. Callahan told me that Mrs. Watson was a very nice person, that they got along extremely well. She said that Mrs. Watson is teaching her now to run tests that she never had confidence to run herself before because she didn't have enough technical training; and she in turn is teaching Mrs. Watson how to get along with patients, so that both women feel that they are learning from each other.

In most hospitals, prestige and promotion are still earned by on-the-job competence more than by formal qualification, and it is possible for a girl trained by apprenticeship to rise to good positions. She is increasingly at a disadvantage, however, if she transfers to another hospital.

Relations with the Rest of the Hospital

The number and nature of contacts between the laboratory technicians and the other parts of the hospital is profoundly affected by the way the work flow is organized, and this differed very markedly among the hospitals we studied. The resulting contrasts were striking. In a large hospital almost all laboratory specimens were collected by the

nursing service and sent to the laboratory. The technicians remained during their working hours within their own four walls, dealing only with such impersonal things as laboratory specimens, identification slips and written reports. In the laboratories of these hospitals, the group feeling was very high, but it was among these young women that we found the greatest proportion for whom the work had little intrinsic interest.

In the other hospitals which we studied the technicians went much more frequently to the nursing floors to collect specimens. Not infrequently they went directly to the patient without speaking to other employees. They tended to be brisk and businesslike in their relations with patients, as it were, transferring their skills of precision with laboratory apparatus to the interpersonal situation. They were not unmindful, however, that their visits might arouse apprehension, and when they saw evidence of this, they tried to give the patient reassurance. Apprehension can change the result of a basal metabolism test so seriously as to render it worthless and can make it impossible to collect an intravenous blood sample neatly and efficiently. The technician needs to be able to calm an agitated patient if she is to do her work effectively. However, we found no instance of formal instruction in the psychological handling of patients and in one case we were told explicitly that this skill comes from observing and talking with experienced workers.

A notable exception to the common practice of going directly to the patient is in the pediatrics ward. Here the technicians were very glad to have the help of the nurses in quieting frightened children.

There seems to be some latent professional jealousy between technicians and nurses. Some medical technologists have gone somewhat further in their formal education than the nurses. They feel that they should have at least equal pay. Hospitals try to keep the groups at the same salary level, but equitable schedules are hard to achieve. Several of the hospital administrators with whom we talked were troubled by the way each group used the pay scales of the other as a leverage for their own demands.

Nursing floors and laboratories run on different psychological times. Nurses may not fully understand the smoothly scheduled flow of tests in the laboratory, while technicians may find it hard to comprehend the rise and fall of daily action on the floor where scheduling must often give way to unpredictable needs of the patients. The failure to understand these differences in tempo is the occasion of some strain

between nurses and technicians. Technicians complain that the nurses delay sending orders down until it is too late to do the test conveniently, so they must stay overtime or postpone the work an extra day. Or, they maintain that the nurse who has neglected a sample will rush it down marked "for emergency handling," when the only emergency is the nurse's oversight. In this way she deflects the irritations of the doctors over the delayed reports to the remote laboratory workers. The occasional technician who has had nurses' training seems to help her colleagues to understand the problems of the nursing floor.

About the only time the technicians have any direct relations with the doctors is during emergency situations, particularly at night, when a technician must be summoned for special duty. These situations are rather infrequent and are apt to be so confusing and tense that they act against the growth of stable relationship. The physician may be brusque on a night call and appear unappreciative of the technician's special services. On the other hand, an expression of appreciation from the doctor for extra service may do much to compensate the technician for the inconvenience she has experienced. Both aspects are shown in the following quotation:

While everyone has been very nice, of course some of them are more so than others. Dr. Klein was very friendly and nice to me. One night I had to work with him from eight o'clock until two in the morning. He kept me busy all evening. I guess he was having one operation right after another. Well then, the next morning he came over and thanked me for all the work I had done. You know little things like that give you a lot of satisfaction. I guess most of them are so busy they more or less take you for granted. They have to rush through their work the same as we do.

While most doctors have a very strong appreciation for the value of laboratory findings in their clinical work, many of them are not familiar with the details of laboratory examination. They order the tests and receive results and give little thought to what goes on between. Misunderstandings sometimes arise over the amount of time it takes to run a test.

The use of antibiotics has brought another source of friction between doctors and technicians. Often a doctor will order bacteriological work and neglect to tell the laboratory that he has given the patient an antibiotic which so changes the appearance of the organism that it is unrecognizable. One laboratory assistant said all the things he had

learned in text books were of no use to him any more and that every day he saw things under the microscope which he had never seen before. Then he would check and find that the doctor had given an antibiotic, changing the whole picture.

It would be a mistake to leave the impression that strain is the characteristic of the relations between the laboratory and the rest of the hospital. It is rather a relationship of formality and impersonality, comfortable enough for the most part but with relatively little human meaning. The most meaningful relationships are found within the small laboratory groups.

Summary

The hospital laboratory in recent years has become an essential element in patient care and its importance is increasing all the time. The examinations which the laboratory performs are growing in numbers and complexity. The work done by the laboratory workers is of two widely differing kinds. On the one hand, diagnosis and research call for an extremely broad and intensive training in medical science, both basic and clinical. This work is done by the laboratory director, a medical specialist. On the other hand, there is much routine testing demanding great skill and precision which come only from long experience and are quickly lost if not exercised regularly but which do not require broad fundamental knowledge. This work is done by the laboratory technicians, whose training requirements at the present time are not well standardized.

The laboratory director is the spokesman for the department to the rest of the hospital. He is responsible for the administration of all the work, but usually delegates the routine aspects to a chief technician. While his reputation is often a source of pride to the technicians, his relationship with them is frequently a somewhat distant one. Each can respect the competence of the others but the tasks of each are sufficiently different that they do not compete with one another.

On the other hand, the relationships among the laboratory technicians, including the supervisor, are close and informal, apparently so much so that they satisfy social needs of the workers. For the most part they have very little need for contact with other parts of the hospital even during off-the-job periods.

CHAPTER 20

THE DIETARY DEPARTMENT¹

IN DESCRIBING THE different departments of the hospital, we have repeatedly said that they are "worlds unto themselves." This notable characteristic of hospital organization is not found in the dietary department. It touches the daily lives of practically everyone within the walls, for almost all have at least one meal there; many employees and all patients are served three times a day. No other department, not even administration, permeates the entire institution and affects patients and staff as intimately and continuously.

Morale and meals seem to be closely related, although this relation may be rooted as deeply in psychological factors as in pure nutritive values. The dietary department is especially vulnerable to criticism throughout the hospital, for everyone not only regards food as important but also considers himself to be an expert judge of its quality. In distinction from the judgment of surgery or laboratory procedures, which can be made with assurance only by fellow experts, food is evaluated on the confident basis of "I know what I like."

Until quite recently, the immense task of round-the-clock feeding was done on a "common sense" basis, and the qualifications for dietary work were simply experience and proficiency in cooking and food-handling. However, the rapid development of such fields as chemistry

¹ This chapter is based primarily on a very thorough draft of dietary problems written by Marvin Okanes. Mr. Okanes' material was drawn from his own intensive study of dietary departments in two large hospitals, supplemented by other investigations of the senior staff.

and physiology in the past decades has led to a great increase in knowledge about the properties of foods and their influence on health.

The science of nutrition has become a field of technical and professional skill. In a hospital, dietetics constitutes an extra weapon in the therapeutic effort. With the development of scientific dietetics, professional workers have been introduced into the system of food preparation. These individuals, the dietitians, have high prestige and have been given formal authority over the artisans (chefs, cooks) and semiskilled and unskilled workers (dishwashers, helpers) of the traditional hospital kitchen. Introduction of such a new group into an established system has raised serious internal conflicts over function and authority.

Most of the important features of the dietary department, then, and the chief problems with which that department must contend, spring from the pressures set up by these two broad facts:

1. The relationship of food to the health and morale of an organization, coupled with the fact that the dietary arts seem to most people less glamorous or awesome than other professional activities in the hospital.
2. The introduction of the expert in nutritional science as a leader in the preparation of food.

The training of the dietitian often encourages her to emphasize further rigidly systematic procedures, where there was already conflict between the necessity for mass production of thousands of adequate meals quickly served at reasonable costs, and the concern of individuals over their unique food preferences.

The dietary department involves large-scale feeding, like a restaurant; it commands a scientific, therapeutic tool, like the various medical departments; it is a focus for feelings of content and discontent. It spans the range of the hospital prestige hierarchy from laboratory studies of nutrition to potato-peeling and pot-washing.

I. Meals and Morale

Many students have noted that beyond its chemical effect on the body, food has a far-reaching effect on well-being because of its symbolic value. Throughout life food is a symbol of security, and hunger the essence of insecurity. We have learned that premature weaning may shake a child's sense of well-being. Obesity sometimes is due to the effort of the sufferer to compensate for insecurities in other relationships through the symbolic security of food. We know, moreover, that

food and drink are central elements in many religious rituals and community gatherings. Eating together is often a sign of special social intimacy. The common meal symbolizes and enhances a pattern of shared outlook and mutual trust. Food is important, then, to the patient as it affects his feelings of security. It is important to the hospital staff as the occasion for a common gathering and as a convenient target for the staff's attitude of well-being or dissatisfaction.

Why does "everyone" complain about the food? Certainly it is in part because the food itself, and the satisfactions and dissatisfactions of taste, are an ever-present interest. Since patients and employees come from many different social and cultural groups that have widely varying food preferences, it is very hard to adjust meals prepared in quantity to individual and group idiosyncracies. Menus must be aimed at the lowest common denominator, which may be a satisfactory compromise, but is not apt to fail to fill many people with enthusiasm.

The problem is aggravated by the decrease or loss of appetite which is such a common feature of illness. The patient and his relatives seem to forget this symptom. He looks forward to the next meal as a break in hospital monotony, but when it arrives he is unable to interest himself in eating and blames the food.

Complaints about food do not arise solely over the food itself. Hospital meals provide a ready scapegoat on which to vent irritations arising elsewhere. The patient who is unhappy, fearful, and insecure in the strange environment of the hospital may easily release his discontent on the quality or temperature of his meals. He may criticize his soup, and indirectly the dietitian and cook, while he might not dare attack the doctor or nurse who is to him the real source of annoyance. Similarly, the harried physician or office worker in the staff dining room may release on the macaroni salad a fund of tension which has accumulated in his relations with his coworkers.

The psychological impact of food on morale is heightened in the hospital, as in the armed forces, by two unique conditions which are characteristic of the clientele: the consumers are under some stress, and are limited in their freedom of choice. It is apparent that patients face a situation of stress, especially if the illness is a serious one. All hospital workers, particularly those with a direct responsibility for patient care, are subject to the tensions arising from the atmosphere of illness. Moreover, the patients can scarcely go to another source of food if they do not care for what is offered. Their immobility restricts them to the diet provided. (The importance of this feature is only empha-

sized by the practice of the occasional wealthy patient who has meals sent in from a fashionable outside source.) One of the first questions asked by inspecting officers in a military installation is, "How's the food?"—not only because of the importance of food itself, but because replies to the question are an index of general morale. Many administrators ask the same question when making patient rounds. The rather full responses to it may be much more valuable as an indicator than would replies to inquiries about other elements of patient care, where knowledge is less certain and expression is apt to be less free.

The dietitian must be aware of these primary psychological elements in the job of feeding patients. In addition to technical proficiency in diet planning, she needs skill in dealing with the reactions of ill people to dietary changes and prohibitions. Insensitivity here may set up emotional resistance in the patient strong enough to cancel any beneficial effects of the diet itself. The head of the dietary department in one hospital showed an especially clear recognition of these factors in her explanations to a student nurse.

You can be a perfect dietitian on paper but your work will all fail if you don't get the patient working with you. For the most part, the patient is supposed to know what's wrong with him and why he's being given the diet, so that he can work along with you. Suppose, for instance, that you put on his plate an order of diced carrots and then the man doesn't like carrots and doesn't eat them? What good did it do you to work that all out on paper—it's foolish, don't you see? That's why when the patient first comes into the hospital we visit him and find out what he likes and dislikes. The patient is supposed to feel as normal as possible, not like an invalid or something special.

I want you to visit the patient every day. If you come down here and tell me that Mr. Morrison didn't eat his lunch, I will not be content with that. I will want to know why he didn't eat his lunch.

A delightful tale from a small hospital recounts the dietitian's problem with an elderly man who insisted on bread and wine for breakfast. He stuck to his choice despite all argument, and won the privilege of continuing his lifelong routine. It was felt that forced change would not have affected his illness favorably enough to compensate for the shock of depriving him of his wine. Many families of recent European origin feel they must provide special foods for an ill member because of group tradition or religion. Although the dietitian, doctor, and nurse may rightfully protest at the introduction of food which is not appropriate to the patient's condition, it is important to recognize the grow-

ing trend to view the patient in his family setting, to consider the social and psychological factors of his position as equal in significance to the strictly medical variables. Flexibility in dealing with the cultural and psychological meanings of food may be increasingly required if the dietary department is to take its place in total therapy as a professional ally of medicine rather than a purely technical service.

If the dietary unit stands in such an intimate relation to patient satisfaction, it is also clearly influential in the morale of the hospital staff. The fact that there is much discussion among hospital administrators of the advantages and disadvantages of separate or common dining rooms for different staff groups points to the key position of eating arrangements in a large organization. Like no other department, the dietary unit is on display each day to all in the hospital, patients and staff. At every meal, hundreds of persons react to the efficiency and skill of the department, and make a judgment explicitly or implicitly. Apart from individual responses to the meal, which affect the dietary department, there are collective patterns of eating, which influence (and are influenced by) the entire organizational tone of the hospital. The student of hospital activities could ask for no better observation post than the dining room. Here he can view the shifting patterns of friendship and professional allegiance, of departmental isolation and cooperation. In a hospital whose laboratories seemed to be very isolated, self-contained departments, it was noted that laboratory technicians invariably kept to themselves at mealtime; they clustered together in a corner of the cafeteria or coffee shop, thus reflecting and reinforcing their solitary position in the hospital structure. The administration at a Western hospital where recent alterations in the cafeteria had been made, commented that the changes had done away with the special sections reserved for doctors, nurses, and other elite groups. This seemed to produce a more friendly atmosphere generally, although the different professions still tended to cling together. In another case, the doctors' special dining room was closed on Sundays, throwing the entire staff together in the main dining hall. The house staff liked to have dinner guests on Sunday noons, but it was found that other hospital employees often took up the space at the tables where the doctors ordinarily congregated. A hospital official sought to solve this problem by placing a sign, "Reserved for house staff," on those tables. But the administrator, sensing the resentment such a message might arouse, replaced it with the notice, "Please keep these tables free for the house staff, so they may be near the telephone in case of emergency."

This is not only an excellent illustration of diplomatic language and clever communication but also shows us the sensitive nature of dining facilities, the way these provisions may actively influence, and richly reflect, the problems of prestige, function, and intergroup relations within a hospital system.

The Job

We have attempted to describe the importance of the dietary department to patient and staff morale, which may well be the crucial, if often overlooked, portion of the job. But it has also a huge task in production and distribution, and in technical scientific planning. The work begins with the ordering of wholesale quantities of food by a steward or, in a smaller institution, by the dietitian or administrator himself. Here, at the very start, the dietary department is deeply involved in hospital public relations, for the distribution of these orders is one basis of the hospital's relations with the leading businesses in the area. As a charitable institution, the hospital historically has often been dependent on special rates and gifts of surplus commodities while doing its grocery shopping. Certain of these special understandings conflict with modern techniques of purchasing and cost accounting, and when they do, something has to give way. To switch from one supplier to another on a perfectly rational standard of price and quality may mean sacrificing the usual Christmas contribution from a friendly but inefficient firm. One small hospital in our experience was faced with precisely this dilemma. In any case, there will be important decisions to make in balancing the orders to various suppliers in the most efficient manner. The hospital in its purchasing is *logically* no different from a large hotel or restaurant; historically and psychologically, however, it is a unique kind of buyer, since it holds a peculiar preferred position in the public mind.

The ordering of staple goods is fairly routine, but the details of supply outside of these commodities depend on decisions reached in diet conferences by the chef and the professional dietitians. These meetings are called to plan menus for several days or weeks in advance. To them, the dietitians bring a scientific skill in balancing food values, the chef a knowledge-of-experience of what is practical and attractive in food preparations.

The chain of operations then involves the cooks and bakers, the food-handlers, the servers and tray-girls, who actually operate the main kitchen and the floor kitchens. At each step these operators are assisted

THE DIETARY DEPARTMENT

by the auxiliary employees who clean, move, and dispose of foodstuffs and equipment, and are overseen by the dietitians, who are charged with quality control and administrative functions. Finally, the patient receives a meal. Then the process begins all over again, for the work of the dietary department is endless. Like so many hospital jobs, this one attracts the attention and skill of individuals with all varieties of training and formal position. From the pot-washer to the physician who prescribes the type of diet, there are many rungs of prestige, and many gulfs that cannot be leaped by even the most conscientious of workers. Yet these persons up and down the line all play some part in the drama of diet, a drama less exciting than, but equally as critical as, that of the operating room, and they must somehow work together.

In summary, the dietary department reflects the great changes taking place in hospitals, from the traditional charitable institution to modern forms of organization. The work has changed from "common sense" craftsmanship to a complicated system involving trained scientists and an elaborate hierarchy of workers. Purchasing arrangements have been shifted from friends to impersonal contractors. The patients are no longer paupers, given food in a charitable spirit, but customers receiving a service as part of their due. There is a general trend toward equality, toward blurring the distinctions between rich and poor patients or between professional and less skilled workers on the staff. This trend is expressed and reinforced by the growing custom of providing one basic—and excellent—menu.

II. Who Does the Job?

There are at least three broad groups who cooperate to feed the hospital, although these groups could easily be subdivided into several more. First, one finds a large number of relatively unskilled workers with minimum technical training and formal education. These are food-cleaners, porters, dishwashers, maids, and others who perform auxiliary services. Some of these are on the way up, learning the ways of the hospital so that they will ultimately hold more rewarding jobs, but unfortunately many have never risen or have sunk to the bottom of the occupational scale. Here are the drifters, the alcoholics, the psychologically crippled, who are the great problem of the personnel manager and the dietitian, because from the point of view of the organization they tend to be "hopeless" cases. Their habits and values simply do not fit into a systematic pattern of work; punctuality, reliability, and ambition are not likely to characterize them. This does

not mean these people are "bad" or "worthless," but different. It does, however, mean that their positive contribution to the functioning of the dietary department is seldom large. Traditionally, these jobs have paid bare subsistence wages and require so little skill that they can hardly be expected to build self-respect in the employee. Low wages, lack of esteem, and poor quality of workmanship seem to go together here, as they often do. The hospital must use individuals who are not likely to become permanently valuable employees and it must be resigned to losing them to more attractive jobs or sheer restlessness.

Yet it is not fair to lump all lower-echelon workers in this transient marginal category. Although the dietary department does attract large numbers of "the nameless ones," it also includes many steady workers who may be described as semiskilled. These workers are distinguished from the transient fringe in several ways. Perhaps most important, they are solidly attached to their jobs so that the work forms a part of their psychological integrity. Their self-respect demands a competent, conscientious performance of duties that are obviously important, although the tasks seldom require a very advanced level of skill or training. One or two brief descriptions of such workers may highlight the differences between them and the marginal employees:

JERRY KRASNA:

A man in his middle fifties, Jerry has worked in the Fairview Hospital kitchen for twenty years. He was hired as a dishwasher and now pushes heavy trucks and hot carts up to the floors. I have never seen him sitting down, and I've never seen him idle. When he came to Fairview, he had never seen a dishwashing machine before and had to figure it all out by himself, but he did it and has been there ever since.

Jerry said that work at Fairview has always been very hard. Once his health broke down under the strain of the long hours; he hadn't wanted to go to bed, but finally did, and when he recovered he began to work in the kitchen again on shorter hours.

"I go my way, and mind my own business," Jerry asserted. "When anything big comes up, I take it to the boss. The house doctors and nurses are pretty nice to me. When patients get cranky with me, I tell myself that's because they are sick; they don't feel good, so I try to treat them real nice."

MRS. SILVERMAN:

Mrs. Silverman came to the hospital five years ago when her husband died. She worked in the tray room and diet kitchen, and then she

was transferred to the nurses' dining room. She loves her present work, taking care of the dining room and adjoining pantry. Mrs. Silverman has a day-by-day schedule made out for her duties, and she sticks to it. She is very proud of the fact that she is her own boss. She remarked that, "The nurses are very nice about saying a good word to you when they enjoy their food."

It should be noted, too, that the nature of kitchen work tends to elicit dutiful activity on the part of employees. A certain dish must be prepared by the meal hour, dishes must be clean and pots must be scoured. The deadline and bustle encourage most workers to strive to meet the challenge of consumer demand. The patients must be fed.

The second, middle group includes the skilled workers who have responsible jobs requiring technical training. Here are the cooks, in their various grades, the persons competent in preparing and serving food, etc. Some of these jobs, especially that of chef, are in the artisan tradition. The food arts constitute an ancient craft with a rich history. The head cooks and the chef usually have a good deal of pride in their craft; unlike the marginal kitchen workers, they seldom present a problem in work motivation, since the tasks have an intrinsic satisfaction and may be pursued "for their own sake." The baker, for instance, is often one of the most highly regarded specialists in the hospital. Like many other hospital workers, this group is, to some extent, caught between the unskilled workers and the professional groups. They must take more responsibility than the ordinary employee, yet they do not have the prestige and salary which reward professional standing.

At the top of the dietary ladder are the professionals who guide the composition of the diet and its relation to medical therapy. Dietitians, expertly trained in nutritive science, and physicians are the chief decision-makers for the department. The doctor does not, of course, have any direct managerial duties, but as in so many aspects of hospital work, his orders set the chain of activities in motion. Actually a specific decision by the attending doctor affects the details of only a small portion of the food supply, that portion composed of "special diets" for patients with unusual dietary requirements. In this area, the physician and dietitian must work closely together. He determines the nutritional needs, she translates them into an appetizing bill of fare. For most cases the doctor makes no special prescription, but puts his patient on the standard "house diet," for which the dietitian has full discretion. Although the doctor's responsibility ends with the speci-

fication of the patient's unique food needs, and their changes with alterations in his condition, the dietitian must go beyond the technical formulation of balanced nourishment in two ways. She has to deal with the patient, to win his psychological acceptance of the menu; and she has to oversee the entire kitchen-to-bedside process of preparation and distribution. We have discussed a few of the implications of her relationship to ill persons. To oversee the work of kitchen and service employees, the dietitian must have some aptitude for management and organization. Thus, she must have unusual flexibility if she is to meet the threefold demands of her job: those of scientific technician, practitioner of the medical arts, and supervisor of a large work force.

III. Internal Relations

The relationships among these three groups—unskilled workers, skilled workers and artisans, and professionals—are the key to the efficient and rewarding operation of a dietary department.

Other hospital groups are important to smooth functioning, especially the patients, nursing staff and administration, but the internal human relations are of primary significance in such a large and heterogeneous unit. In discussing several hospital departments we have stressed their tightly knit, homogeneous character, and their smooth and comfortable internal relationships. Laboratories or outpatient clinics are typical; their problems of cooperation seem to be primarily with outside departments. The dietary department, however, is an illustration of a loosely knit group or collection of groups, which tend to pull apart and disrupt the inner working order. Its most significant problems of cooperation appear to be internal, between the three main groups, unskilled workers, skilled workers and artisans, and professionals. A few central tensions may be examined.

Cook-Dietitian

The cook is traditionally the master figure in any kitchen, the individual whose skill makes dining a pleasure rather than a mere habit. A chef is an honored man in large hotels and restaurants, although his prestige is perhaps higher in Europe than here. In the hospital, too, cooks and the chef are recognized as important skilled craftsmen, but the development of the dietetic profession has imposed a supervisory layer over them. Most artisans, whose competence is the result of long years of practical experience, are apt to be extremely

proud of that competence, and jealous of their independence of action. When the dietitian is introduced into the food-preparing organization, she often brings a passion for order, for the systematic patterns suitable to a highly technical profession; the kitchen and its environs may then be seen as a fit place for an engineering approach. Even more often, she may be so involved in the intricacies of nutritional science that she tends to neglect the "practical" considerations of kitchen management. Thus the special diet kitchen, the scene of her scientific planning, may become a refuge or sanctuary to which she retreats in the face of too difficult problems of human relations. In any case, the cook is apt to see her as an intruder in his special province.

It has been found that these potential grounds for conflict between cook and dietitian are heightened by certain features of the flow of work, especially last-minute changes in meal requirements caused by changes of diet on the doctor's orders, which often occur too late for a corresponding change in the dietitians' demands on the cook. He may then discover that he is short of a particular item or (more usually) faced with large quantities of leftovers which may become waste.

In one large hospital, the cooks had formed a united front against the dietitians on the question of returned food:

See these pans? They've got special diets in them. The same things happen every day. The dietitians give me an order and I make it up as called for. Then half of it comes back not served. The dietitians tell me that when they get up to the service kitchen they find that the doctor has changed the order. That's what *they* say, but I don't see how half of the orders could be changed in one day.

The problem of inefficiency comes from the poor planning on the part of the dietitians. They are young girls who are college graduates, but they don't seem to have learned anything. They would never be hired in a restaurant or hotel.

The dietitians always overorder. If I didn't cut down on orders, we'd have a man peeling potatoes all day long.

The dietitians, in turn, explained that overordering was inevitable because of last-minute changes in patients' diets:

I am aware of the gripes in the kitchen concerning food returns. But this is almost impossible to control. Surgery and other ups and downs in the patient's condition bring about shifts from house diets to soft or

liquid diets and vice versa. We have to have extra food ready to cope with these sudden changes.

This is a source of conflict with the chef. For example, he doesn't want to waste potatoes and I sympathize with him. It's a shame to waste say twenty potatoes during the shortage, but it's not really a waste because it's more important to be able to feed the patients than to throw out some potatoes.

We usually have to order food for more patients than are actually occupying beds at the time of ordering. We must anticipate new arrivals before the next meal. Then we always order more than necessary because the cooks cut down on us.

Cooks and dietitians complicated the problem in this hospital, as the last remark reveals. They had set up a vicious circle, in which constant exaggeration by the dietitians followed constant reduction by the cooks. It is a clear instance of what Robert Merton has described as the "self-fulfilling prophecy." The people involved predict an event and then ensure that the event will happen by altering their behavior to fit the expectation. "Overordering" by dietitians begets "stinginess" by cooks and vice versa.

Cook-dietitian relations in another institution studied were far more harmonious, although the difference in prestige between artisans and professionals, and the trials of diet changes, were still present. In the second hospital, dietitians and cooks were all women, while in the other the cooks were exclusively male. The sex distinction appears to be an important element; it re-enforces the problem of rank, for men in American society are not ordinarily accustomed to taking orders from women. In the organization of the dietary department, the professional dietitian initiates a chain of action for the kitchen personnel. When the cooks are men, and men proud of the dignity of the culinary craft, there are obvious resistances to following the dictates of women.

The cook-dietitian conflict, when it is found, is a particular case of a tension which pervades many other hospital departments, and virtually any organization. The general tension is that between the veteran practitioner whose skills have been gained on the job through a wealth of experience, and the (usually) younger person whose claim to knowledge and authority is rooted in formal schooling and professional credentials. This tension may be observed at all levels, including those of physician and administrator. In the industrial scene its appearance has been remarked in the interplay between the "college boy" engineer and the long-service foreman.

Unskilled Worker—Supervisory Personnel

The gulf between the college-trained dietitian and the transient worker is too wide to be easily bridged. They are separated by private worlds of experience and ingrained value systems, so that a common view of any situation is very difficult to achieve. Close to the dietitian in some essential attitudes, and quite far from the unskilled workers, are such figures as the personnel director, the administrator, the chef, and the steward. A long list of contrasts might be compiled, but perhaps the basic one, for our interest, is found in the attitude toward the job. In many hospitals, the dishwasher, the helper, the porter, and others in similar positions, seldom stay with one job very long or develop much loyalty toward the organization of which they are a part. To many of them, a job is a necessary evil, but yet an evil: a thing to be endured as conveniently as possible in order to gain an immediate cash return. The dutiful aspects of work in our society seem especially onerous to them, partly because their background has not taught them to accept the responsibilities of work as normal and right. Further, they are often rootless, moving from job to job and from city to city, without a circle of family or friends to stabilize their pattern of life. The common result is that, to the conscientious worker or supervisor, the unskilled fringe employees seem careless, irresponsible, and even morally offensive. Alcoholism and theft by the marginal workers frequently plague the hospital. Yet these clear transgressions of "well-bred" behavior probably give the supervisor less trouble than the cumulative effect of minor disturbances from tardiness, absenteeism, and the failure to assume responsibility for the essential purposes of the hospital organization.

A variety of anecdotes are available to illustrate the trials of supervisors with the transient worker. They are usually told in a half-exasperated, half-humorous tone, and express a sense of helpless frustration.

I came in this morning and found that only twelve out of my eighteen workers were on duty. It's always this way after pay day. You can't count on your work force in advance. You always have to be ready to juggle people around.

—A dietitian

Our kitchen workers often put up at the City Mission until they have earned a first paycheck. The other day a girl called from there and said

one of our employees had just made her a gift of a large ham. She felt sure it must have been stolen, and questioned the man, who admitted taking it from the hospital. He saw nothing wrong in spiriting a ham away for someone who had befriended him. Well, we finally got the ham, a twelve-pounder, back.

—A personnel manager

Underlying specific complaints is the general feeling that one cannot understand these workers or deal with them rationally. At a supervisors' conference a dietitian threw up her hands saying:

Our kitchen help are just impossible. You can't count on them unless you supervise all the while. I don't understand their attitude. Yet, sometimes they will work very hard if they happen to feel like it, or be feeling friendly toward you.

One does not find a very definite counter-attitude on the part of unskilled fringe employees. Some resentment, some tolerant amusement is visible, but for the most part they "just don't care." That is, they have no heavy commitment to the job and since their involvement is so much less than that of the supervisor, they do not have to take the situation seriously. Another job can be found, and if the atmosphere becomes too strained or the duties too rigid, one can move on.

These breakdowns in understanding between the poorest-paid workers and their supervisors seemed to be taken for granted as inevitable parts of some dietary departments. That they are not inevitable was demonstrated by the experience of other hospitals where lower echelon workers were relatively stable and responsible. Some of the difference may have been due to geographic and cultural factors beyond the supervisors' control. For example, one hospital in a small town, where jobs available to local housewives were scarce, was able to find steady conscientious workers, while a big city hospital was in a rooming house area where there were almost no housewives with an interest in part-time or split-shift employment. In a medium-sized city one denominational hospital attracted coreligionists who could take such jobs without loss of face because they could see themselves as helping in a good cause, and felt respected by the hospital administration as persons of good will. The problem of positive motivation is a complex one. Appeals to altruism cannot be seriously proposed as a substitution for an adequate wage. Yet, some combination of factors is at work here, and should be seen in a balanced perspective. Workers need the

self-respect which accompanies a decent income, as well as the sheer economic reward. A job should also yield psychological satisfactions, or at the very least not be seen as degradation. Part of the problem of the unskilled worker's integration into the hospital system may be his own, but part of it may also be attributed to the supervisor's difficulty in accepting such workers as respected collaborators in the hospital effort. The very rootlessness of some of these people, their lack of close family ties, accentuates their need for acceptance and warmth in work relationships.

Part of the more successful integration found in the smaller hospital may lie in the closeness with which the professionally trained dietitian often works with the rank-and-file employees. This was well illustrated by an incident in a medium-sized hospital. Here the head dietitian had discovered an assistant dietitian washing dishes, and had stopped the practice, thinking her behavior inappropriate. The assistant explained that one dishwasher was on a day off, and that the other had reported absent because of illness. So, she had pitched in. This event is interesting because it contrasts so sharply with the more "professional" outlook of dietitians in large hospitals, where dishwashing would be unthinkable. In very small organizations, the limited division of labor creates an atmosphere in which tasks of "the kitchen" are nearly interchangeable.

IV. The Dietary Department in Relation to Other Hospital Groups

We have pointed out earlier how the feeding of patients and staff inevitably brings the dietary department into touch with everyone in the hospital. Many dietary employees, especially the dietitians themselves, are alert to the comments of the consumers as they react to the daily menu. In one large general hospital, a dietitian remarked that she often learned a great deal from the offhand reactions of the staff as they filed through the cafeteria line; she went on to explain that the tone of these reactions had a perceptible effect on the morale of the dietary people serving the food.

Perhaps the most significant groups with whom the dietitian must cooperate are the doctors and nurses. The administrator, to be sure, exercises a general supervision and may make frequent inspection trips to the kitchen, but it is obvious that he cannot participate in detailed arrangements. Patients are in one sense a "constant" factor: there will

always be a few malcontents, whom no diet will please. There will always be a fair amount of complaining since food is such an excellent, available target for irritation, although the dietitian may reduce this through sensitive understanding in her orientation of new patients. But the work flow is drastically affected by the continuing interplay with doctors and nurses.

Dietitians and doctors confer directly over only a fraction of the total patient load, but for these special cases their understanding must be thorough. The dietitian has an increasingly strong voice in these consultations as she gains recognition from the physician as a highly skilled professional colleague. And the recognition itself, the establishment of a colleague relationship, is of course a rewarding thing for the dietitian, as it is for all members of professionally striving hospital groups. For instance, the chief dietitian at a small hospital described the visit of one of the staff doctors to the diet kitchen. He had gone out of his way to thank the chief dietitian for the good care one of his patients had received:

It is very gratifying to have a doctor pass some of the credit on to the diet kitchen. I called all of the girls [student nurses] into the office to let them hear what the doctor said. They learn more that way than they ever could from a class on patient care.

Doctor-dietitian relations parallel, in certain important ways, those between doctors and laboratory workers or between doctors and social workers. The dietitian provides a special, technically expert service of fairly recent origin. He must learn to use it, and she to offer it, in a spirit of mutual respect, if the highest therapeutic benefit is to be available to the patient. Diet is part of the doctor's job, and his decision guides the course of diet therapy, but he cannot be expected to have as full a grasp of detail as the dietitian who makes it her life work.

Yet the interaction of dietitians and doctors is seldom close or truly reciprocal. Especially in larger hospitals, it is often limited. In one large institution, it was virtually restricted to two dietitians who were responsible for therapeutic diets. Even they had to seek the doctors on the nursing floors if they had a specific problem. The doctors were not observed to visit the department.

One situation which recurs to complicate the dietitian's life is seen in this comment by an assistant chief dietitian.

Something that might be corrected is the practice of the doctors giving late notice on the proposed discharge of a diabetic patient. They are

supposed to give twenty-four hours' notice on this, which is necessary so that arrangements can be made for instructing the patients about their diets before they leave the hospital. But often the doctors won't give us enough notice. In fact, on the day before a holiday, we check with the nurses on the floors so that we don't catch ourselves short on personnel on that day—in case a diabetic patient is due for discharge.

Similar occasions for misunderstanding are found in hurried changes from one type of diet to another, and we noted earlier how this can set off a chain of "crossed signals" with a negative effect on cook-dietitian relations. These problems do not usually carry the heavy emotional charge, the strained intensity, of an interpersonal explosion in surgery or on a patient floor. Yet any persistent flaw in communication must be carefully examined, for although the quick change and the missed signal are inevitable in a fast-moving organization such as a hospital, when these minor incidents build themselves into a pattern they may indicate basic confusion of duties—or basic antagonisms in intergroup relations.

Nurses may often develop an unfavorable impression of the dietary department during their student days, if they find themselves used as "free labor" during their tour of duty in the diet kitchen. In one institution students were assigned to potato-peeling and other tasks which contributed little to the growth either of knowledge about the department or sympathy with its problems. On the other hand, in a hospital where student nurses delivered food to patients and discussed dietary problems with them, very favorable attitudes toward the department were stimulated. At this institution the dietitian held ward classes to consider dietary questions and various patients' cases in detail. The situation seemed to be one of learning, with little evidence of the "exploitation" which sometimes occurs, or is felt to occur, by students during their assignment to the kitchen. The instructor in the ward classes would question the students closely about both the medical explanation of a particular diet and the psychological features of the patient's reaction to it. All in all, the students appeared fascinated and thoroughly involved, since dietary information was made meaningful by being fitted into a larger framework of diagnosis and treatment.

At most of the hospitals about which we obtained information in interviews, either concerning the current hospital or those at which the dietitians had previously worked, there appeared to be a general feeling that relations between nurses and dietitians were not of the

best. When a dietitian at a medium-sized hospital was asked about her relations to graduate nurses, she replied:

Well, they don't bother with us so much. I don't know why that is; somehow we don't get the same consideration as the nurses do here . . . the nurses get a day and a half off every week and we only get one. I don't think they feel that we are quite on the same level . . . maybe they [the nurses] think we aren't as important but I don't see why they feel that way.

One reason that may account for this attitude of nurses toward dietitians is the fact that nurses were part of the hospital organization long before dietitians appeared on the scene. Nurses may feel that dietitians are taking over what was formerly a very important aspect of nursing art.² A chief dietitian suggested such a problem when she described the resistance which she found to the introduction of more businesslike controls in the department:

When I first came, the graduate nurses were coming down in the kitchen and helping themselves to food. They would just go right in the icebox without saying a word to anybody and help themselves. I don't doubt for a minute that they were doing it for their patients. I don't mean that I thought they were eating it themselves, although maybe sometimes they were doing that too, but the point was that nobody knew where the food was going. We didn't have any control over it at all.

Q. Then you ran into resistance all over the hospital, not just in the kitchen?

I'll tell the world I did, especially with these older nurses. They just couldn't see it at all. They were getting away with murder all these years, and they just couldn't see it.

Dietitians reported that they almost never associated with doctors or nurses socially outside of the hospital. One explained:

. . . nurses and dietitians don't get along with each other because the nurses feel that their kind of work is too far above the work done by dietitians. When I was at Bergsville Hospital, I lived at the nurses'

² In medieval times there was no clear distinction between dietetics and pharmacy. Medicinal and culinary herbs grew side by side in the hospital garden, and the preparation of vegetable "simples" was based on kitchen lore. Recipes for "cooling draughts" and for foods calculated to correct some imbalance of the "four humors" were among the most precious possessions of the hospital. It was in supervising their preparation that the nurse exercised her highest skill.

home and you could argue out certain situations with them after working hours. Here you're somewhat isolated from the nurses except for your contacts on the job.

A conspicuous example of closer and warmer relationships between these two groups was found in a very large metropolitan teaching hospital. At this hospital there was a high degree of formal organization; such thorough planning sometimes tends to separate people, and observers commonly speak of the "coldness" which distinguishes a bureaucratic structure, but here the lines of organization seemed to knit the professional groups together. Part of the reason appeared to lie in the sheer physical proximity of nurses and dietitians, which meant they were better acquainted and more adept at communicating with one another. For a more efficient pattern of operation, the floor dietitians had desks placed beside those of charge nurses so that dietitians might supervise the work taking place in the nearby service kitchens. This resulted in almost continuous interaction between the two.

In addition dietitians interacted more frequently with doctors and were included with nurses on daily tours of patients. At this hospital it was not uncommon for a young medical interne to seek dietetic advice from a floor dietitian after an informal relationship had been established.

The relations between dietitians, nurses, and doctors in this institution may be gleaned from the following interview data.

The assistant chief dietitian remarked:

The relations between nurses and dietitians are better here than at the Burrough Hospital (where she had previously worked) because the nurses and dietitians work in close proximity to each other so that if, for example, a dietitian forgets some kind of slip or order, the nurse merely has to speak across the desk to her and the situation is straightened out. In a case like that the dietitian just has to say, "I'm sorry, I forgot it," or something like that, and it's all okay. But when you have a central diet office, the nurses have to call down and ask for things and point out little omissions such as these, which tends to antagonize the relationship between nurses and dietitians.

One of the floor dietitians who had worked at several hospitals said:

At this hospital the dietitians are treated as "people." The relations between dietitians and nurses and between dietitians and doctors at the

Bigtown Hospital were particularly bad. These relations were better at Northern Hospital but not as good as here. At the Bigtown Hospital the dietitians were in a constant fight with the nurses. I feel that the relations at this hospital between dietitians and doctors are particularly good.

Another floor dietitian offered the following:

Relations between dietitians and nurses at this hospital are extremely good. It is common knowledge that dietitians and nurses at other hospitals generally do not get along with each other. That's because nursing has been accepted in the hospital for a long time, but the dietitian is a newcomer to the hospital and is not fully accepted. One reason for the friction is that the nurses who were trained in the old school feel that dietitians are tramping on their toes and taking over some of the responsibilities that should be given to nurses.

In a highly organized hospital, then, the work groups may be so aligned that they develop something of the mutual trust and identification which the smaller institution often boasts. The portrait of cooperation on the professional, technical level which emerges from this series of quotations is frequently paralleled by intimate bonds on a different level. These less explicit ties may be forged as a result of the circumstances which make the dietitian or baker especially capable of doing small favors for staff and patients. The birthday cake for a veteran nurse, or the candy favors made by one dietitian for patients at Easter, are not usually feasible in a very large hospital; in smaller hospitals, where such features can exist without serious interference with the central task of patient care, they contribute a great deal to the institutional image of the dietary department.

Even in the best of circumstances, the hospital faces unusually difficult problems in mass institutional feeding. The preparation and serving of food on a large scale is a complex operation in itself. In the hospital the hazards of this operation are compounded by the difficulties inherent in a very mixed clientele, a long gap of time between cooking and serving, and the special role of food in the psychological economy of the ill.

CHAPTER 21

COMMUNICATION NEEDS IN A GROWING INSTITUTION

AN OFFICE EMPLOYEE with many years of service behind her described the way her hospital had grown and the effects this had had on the people who worked there:

In the old days this hospital was like one big happy family. Everyone knew everybody else, usually by his first name. Some of us used to be able to do several jobs. Why, I would be on the switchboard for a few hours, then make some admissions, then maybe take the information desk for awhile. Of course, that was when the switchboard was right next to the office. And it was so friendly... Miss Jacobs (the administrator) had her office right across the hall so we saw her all the time.

Lately it seems as if the old atmosphere has gone. You don't even know half the people you see in the halls. You smile at them because you *should* know them, but there are just too many new faces to keep track of. We can't switch jobs any more either, because everything is in a different part of the house. I hardly ever see any of the old gang. Somehow it seems colder, as if the spirit had gone out of things. It's more like any other job now.

Remarks like this were so frequent in our interviews as to become routine. The changing scene had done something to employees to chill their spirits. Moreover, the problem of coordination was obviously becoming acute. People no longer "spoke the same language."

The French sociologist Emile Durkheim had important things to say about the division of labor and its relation to communication

needs. He pointed out that in the simpler societies known to us, communication problems did not seem to exist. People knew nothing of the outside world. Changes in their own small world were few and far between. Behavior was governed by tradition: everyone knew how to act—all he had to do was follow the patterns laid down by his ancestors. What is more, everyone did just about the same things as everyone else. Almost the only division of labor was between "men's work" and "women's work." Therefore there was a ready understanding of each other and explanations were unnecessary.

As a society becomes larger, Durkheim suggested, a division of labor occurs. Men must specialize in their types of work if everyone is to be fed and clothed. It is with this specialization that communication difficulties begin to arise. If society is to continue to hang together, people must learn what to expect from one another and what they, in turn, are responsible for. The basis of unity changes from tradition to law. People with different functions learn to cooperate according to rules known and acceptable to all.

Formerly hospitals were almost worlds within themselves. Many employees lived, worked, ate their meals, and enjoyed fellowship within their walls. The chief division of labor was between men (doctors) and women (nurses). Turnover was slight and tradition was paramount. The individual soon learned what was expected of him, partly because it wasn't very different from what was expected of others, and partly because any attempt on his part to change the pattern was sure to bring forth the protest, "but we *always* do it this way."

In the preceding chapters we have related how multiple changes occurred in hospitals and in their functions. With the changing technology and the increasing number of patients came a steady increase in the numbers of employees and in the division of labor among them. As people became "specialists," e.g., a telephone operator or a receptionist but not both at once, the old feeling of solidarity was lost. A stage of transition was reached wherein people seemed to have few shared understandings. Communication became a problem.

The task of this chapter will be to explore what happened when the old basis for unity was lost and how coordination was sought for and gained within the hospitals which we observed.

Bureaucratic Controls, Their Cause and Effects

Chapter VIII which dealt with the head nurse described the changing organization of the nursing department. At one time a highly

centralized form of control existed with the Director of Nurses running the department virtually singlehanded. Later, as the hospital grew too large to permit effective government by so simple a line of command, power came to be dispersed among many persons. Head nurses grew to control their own floors and one autocrat was thus displaced by many small ones. Finally a third stage was reached in which the hospital nursing floors were being reunited under one line of authority.

This development within one department reflects what happened in the hospital as a whole. The administrator formerly held a tight grip on his organization, delegating authority only to the director of nurses. In a sense, they were dividing men's work from women's work, for she directed mostly female employees such as nurses and maids, while he assumed direct responsibility for the employees in the heating plant, the maintenance workers, and so on. In some situations the administrator in addition did all the purchasing, distributed supplies except for linens and medicines, handled all incoming and outgoing mail, and visited each department personally at least once a day, in some cases stopping at every bedside. As departments were added, hospital business continued to be routed across his desk, each department head taking matters up with him and leaving interdepartmental problems in his hands. It might be said that communication was vertical, from lower levels of the hierarchy up to him and back down again. Horizontal communications across departmental lines were limited strictly to informal matters.

When hospitals grew in size and complexity, increased stress began to weaken this ancient system of control. Bottlenecks were blamed on the changing times, but they could not be excused forever, and the administrator who tried to retain full supervision of details in a growing institution began to find his day so crowded with trivial matters that he had no time left for problems of general policy. Either he had to neglect some areas while he concentrated on others, or he faced the necessity of making basic changes in the pattern of organization.

Just as in the nursing department, some organizational changes seemed to occur without planning. Strong-willed department heads, impatient of delays, pushed against this pattern of dominance from the top and began to win more control over their segment of the hospital. They got permission to order their own supplies, for example, to hire and fire their own employees. In a few instances a series of aggressive and growing departments began to vie with each other for influence

over interdepartmental matters. In place of a closely unified institution under one head, one might see a cluster of departments uneasily held in check, or even worse in a state of perpetual war with one another.

One way an administrator could maintain order in a mushrooming organization was to tighten paper controls. For example, where one department head had been ordering his own supplies and another asked the administrator for them by word of mouth, now both were asked to submit formal requisition sheets at stated times of the week. A junior clerk (or possibly the administrator's secretary) was given the task of combining these departmental requisitions into one master order so that supplies could be purchased by bulk and careful records kept of price changes. Later still a person skilled in purchasing may have been hired to handle this aspect of hospital business. Purchasing thus came once more under the province of the administrative offices but in the hands of a staff person rather than of the administrator himself.

Similarly in the course of time other staff positions were created within the hospital organization. Storekeeping was centralized, the employment of personnel, the handling of medical records, the making of solutions for nursing floors, all these developments were handled in a way which yielded the possibility of checking back, discovering mistakes and assigning responsibility in the absence of close immediate supervision. They also represented, it may be seen, a change in the communication system. Between administrator and department head there came a series of pieces of paper, and a new level of staff employees whose job it was to handle this paper traffic. The personal touch, the old intimacy, was threatened by these new developments.

It wasn't always easy for people within the organization to accept such changes, especially where new personnel was brought in to help implement them. Many expressions of discontent were voiced in our interviews:

Who is that little snip of a storeroom clerk to tell *me* that I have to wait till Thursday to get supplies?

We heard outraged nurses express defiance and willfully go hungry rather than go through the formality of asking a new dietitian for their meal when their duties in the operating room kept them busy until after mealtime. They had been accustomed to helping themselves from the icebox. It is hard for people to accept such changes when they see them to be infringements on their freedom of action. This is

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especially the case, of course, when the person who has had some power in his hands sees it being taken away and given to someone of equal or less status in the organization. The "outsider," the newcomer to the organization, becomes an easy scapegoat for discontents.

Building an Administrative Team

As the problem of coordinating the increasingly restless departments grew more intense, a development occurred in some institutions which was quite a departure from tradition. This was the bringing together of department heads to form an advisory council or an administrative team, as it is sometimes called in industry. In this situation department heads who formerly were responsible only for their particular segment of the hospital were now asked to participate in the responsibilities of total hospital management. In the past they had channeled orders down the line to their own staffs, and perhaps some suggestions up the line to management, but always the direction of communication had been vertical. Now they were being asked to take on what might be seen as horizontal communications, passing ideas back and forth across departmental lines and thinking of the whole hospital rather than just their own segment of it. This was clearly a sharp change in outlook and responsibility for them. Just as in so many other places throughout the hospital, we found a transitional state during which some people caught on to new ideas and made notable contributions, while others floundered along miserably, not quite sure what was expected of them.

In order to see what is necessary to achieve willing cooperation among departmental groups, it might be worth while to consider one extreme case where this was successfully done. After describing it in sufficient detail, we shall attempt to analyze just what made it successful.

This hospital was run by a religious order, and since it was the only one of its kind studied we do not know to what extent it was typical. The Sisters held the belief that it was good spiritual discipline for each of them to do all kinds of work. For this reason a Sister in charge of the most exclusive private floor might find herself suddenly transferred to the laundry. Another, trained in physiotherapy, might be placed in charge of the drug room. Whatever disadvantages this had, and certainly there was a price paid, one of its results was that almost all of the Sisters had a good bit of knowledge about departments in addition to the one in which they were currently employed.

They developed an institutional, rather than a departmental, loyalty. Their institutional arrangements came to reflect the fact that they believed all types of work to be equally important. For example, the offices of the director of nurses and the housekeeper were side by side on the first floor, identical in size, equally well furnished and equally accessible. There were no "orphan" departments and all had high status.

The Sisters had similar training, including education in administration. They "talked the same language." Since they ate all their meals together, shared common recreation rooms, and had experience in each other's departments, there was an unparalleled ease of communication among them. Officially the department heads (and all were members of the Sisterhood) reported separately to the administrator who held all formal power. Actually the administrator encouraged them to settle their differences among themselves wherever it was possible.

This was admittedly an extreme case and nobody would seriously suggest that a secular institution should attempt to duplicate such a pattern of relationships. Since it was a good example of integration within a hospital, however, we might examine it to see what we can learn from it, whether some of the advantages of the close-knit community might be acquired in other ways. It seemed to us that the crucial elements here were (a) clearly defined formal power, (b) freedom to communicate across departmental lines, and every encouragement to do so, (c) familiarity with the problems of all other departments, (d) similar educational background which eased the communication of ideas, and (e) common membership in an order stressing service and high motives.

Formal Power, Clearly Defined

In this particular hospital there was an easy relationship between all levels and people expressed their views simply and forcibly upon occasion. At the same time, it was perfectly clear that everybody knew where authority and responsibility lay. There was no question about power relationships. This, of course, fits well with all the rules about good organization. People work better when they know where they stand in relation to others, who their superiors are, and for what things they will be held responsible. However, it is easier to know such rules than to practice them, particularly within an organization which is expanding rapidly. In some hospitals it must have seemed to

bewildered employees as though a new set of policies came out every week. In the institutions we studied, it was realized that the informal understandings of the past were no longer sufficient. Every effort was being made to provide guides to employees in the form of job descriptions, written personnel policies, organization charts, and so on. Lines of authority and responsibility were clarified, occasionally with too much vigor perhaps, although this certainly wasn't an inevitable result. One incident may serve to illustrate how flexibility can be retained even in the face of formalized policy. A head nurse was instructing a new nurses' aide and handed her a written job description. As she did so she explained:

Here is your job description. These are the things you will be held responsible for, but I think you will find that people here are pretty cooperative. If you give them a hand upon occasion, they will help you out when you need it, too.

This particular department was characterized by ready cooperation among its employees and one can see how it stemmed from the attitude of the head nurse.

Communication Across Departmental Lines

In one hospital the employees told us somewhat tartly:

Listen, the reason this place runs is not because of the organization but in spite of it.

We found that within this hospital there was a network of informal relationships which united people together as personal friends. Almost any problem could be taken care of simply, one person phoning the other and by common consent shortcutting the red tape. That was true in all the other hospitals as well, although not always to the same degree. The hospital just wouldn't run if employees didn't get together across departmental lines when emergencies arise. To give one small example, suppose a piece of oxygen equipment goes out of order. If the nurse were to report it to the head nurse, she to the chief engineer, and he to the repairman, the patient would probably be dead before the equipment was fixed. A short cut is taken in such a case. The nurse phones the maintenance office and the repairman, ignoring all rules of "first come, first served," drops everything and comes on the run. Everybody who works in a hospital knows this, but sometimes it embarrasses

them. They feel that it would be better form if everyone "went through proper channels."

All organizations have need for both vertical and horizontal communication lines. The vertical ones unite the levels of the hierarchy, so that policy formulated by top management is communicated to the rank and file, and grievances or problems of work-flow experienced below can be carried back up to authorities for correction. Where there is a relatively simply flow of work, as on an assembly line, the vertical channels of communication are much more nearly sufficient to keep the organization running smoothly than they are elsewhere. A machine breaks down, the employees report it to their supervisor and then sit down and wait for corrective measures to be authorized. Nobody dies. In a hospital it can't be handled like that. In fact, we are finding that any organization in which customers and employees meet in a face-to-face relationship must of necessity allow greater flexibility at the lower levels. Employees must meet the needs and desires of the customer who faces them. This means that they have to use judgment. They must have freedom to adapt general policy to meet specific needs. That means they must know policy and also know how much leeway is allowed them in adjusting it.

In our experience, the coordination of people and services in hospitals is amazingly good. In fact it is almost phenomenal that so many patients are cared for so adequately. This is due, in many cases, to good horizontal communication which has arisen informally, without planning or even in some cases without sanction on the part of formal authorities.

Obviously problems do arise when people take shortcuts. Two employees somewhere down the line of work may get together to ease the path of one patient. They may have the best of intentions, but because they lack an adequate perspective on the total organization they may only succeed in making life more difficult for everybody. When this happens, management may be inclined to clamp down on such voluntary cooperation and attempt to enforce a stricter conformity to rules and to vertical communication lines, when what is needed is better informed employees rather than simply more obedient ones. Employees must know not only their own jobs but should see how their work fits in with that of others. They must have a feeling for the organization as a whole.

In the case of the hospital mentioned above, that feeling came

through the closely united Sisterhood. What other ways can be used to create this feeling?

Staff Meetings

One way to achieve a common understanding is to provide a meeting place where ideas can be freely exchanged. Get representatives from all departments around a table and let them talk things over; that has a good, wholesome sound to it. Yet, in some of the hospitals we studied, the suggestion brought quick frowns to the faces of some disillusioned people. They had tried holding meetings, with disheartening results. It might be illuminating to consider some of the problems actually encountered.

In one situation there were cries of outrage when a hospital school of nursing was denied a grade "A" accreditation on the grounds that it lacked formal faculty meetings. The thing which hurt most was that a neighboring school received the coveted "A." The deprived administrator protested:

This is silly. It is just plain silly. Why, our faculty meets every day at the lunch table. They talk things over all the time. Now what do they want a meeting *for*?

A study of the second hospital, the one which received the "A" revealed these differences. The faculty here also met every day for informal give and take, talking things over as individuals. When they met in faculty meetings, however, the things they talked about were of a different kind. These weekly sessions represented a self-conscious and systematic attempt to review the school program and to develop a unified spirit concerning it. Ideas were regularly brought in from the outside by persons who were assigned the duty of reporting on them. Even the keeping of records, the sometimes tiresome reading of the minutes and formulation of agendas, represented this same systematizing force. Putting things down on paper, like discussing them in open sessions, acted as a control device. It became more difficult for individuals to act in a capricious fashion afterward. It might be said that the whole phenomenon was one which led toward controlled progress.

Another hospital experimented with meetings for its general duty nurses. They had never before been given an opportunity to sit with top administration and when the great day came, an explosion occurred. No sooner did they come together than the nurses began telling the

president of the board how terrible the food was! The outraged administrator commented the next day:

How can they sit in judgment of management when they have never had experience in it? Imagine talking like that to the President of the Board! In the old days people would have to work at a place for years and years before they were given opportunity to make suggestions to management. I think we have gone too far in giving youth its say. They don't know what they are talking about....

This reaction might be paired with that of another reported failure. This was a meeting of departmental heads which met for two or three times and then faded out of existence:

We used to meet in what we called a departmental day. Every meeting we would take somebody apart. One time it would be the nurses, the next time it would be the laundry or the dietitian. The day we took the dietitian apart she broke down and cried, but it was really what she needed. You see, she more or less set herself up on a pedestal, she took the attitude that she was on a professional salary and you weren't, and therefore her job was more secure. I think that meeting helped her a lot to see how other people felt about it.

Whether or not it helped the dietitian, the fact remains that these meetings promptly died out, and one could guess why. No matter how enthusiastically the group may have joined in to criticize the dietitian, what possible motivation did the remaining department heads have for looking forward to their turn on the block? Certainly one might expect that one after another they would begin to find it "inconvenient" to attend meetings. If a new experience is to be repeated willingly, the psychologists tell us, it must be seen as a reward and not a punishment. This is at the root of all learning.

Why would an administrator who is used to doing all the talking and all the decision-making want to sit and listen patiently while half-informed persons criticize his past performance and make "crackpot suggestions"? There must be a strong feeling on his part that some reward will follow the punishment. For example he might work on the theory that by talking things over first, people will become more ready to accept change and to participate willingly to bring it about. If he looks at it that way, he will endure the suffering which the sharing of decision-making means for him. Otherwise his patience will wear thin.

likely to produce favorable results just because people have a deep personal involvement. Each one can see where he and his group fit in and what contribution he can make most effectively. The fact that the group is dealing with a change in activity rather than with news alone, makes it more meaningful. When agreement is finally reached, assuming that it represents an honest consensus of opinion, all those who participated in reaching it can be expected to work to win its general acceptance.

The phrase "an honest consensus of opinion" is the key to the sentence above, of course, and the key to the success or failure of many meetings. The element of leadership is such an obvious factor that one almost hesitates to mention it. The form of democracy doesn't mean very much if the substance is missing. People accept leadership but they expect that it will be cognizant of what Quakers call the "sense of the meeting." The leader can't, in the last analysis, go flying off on a tangent of his own in disregard of the group's will unless he is willing to forfeit their support. The real test of effective leadership lies in the willingness of the rank and file to implement his decisions with action.

Perhaps this is the place to reiterate that democratic procedure doesn't mean rule from the bottom either. The hospitals in which we saw most efficiency and harmony were quite evidently run from the top down, the supervisory staff serving, so to speak, in advisory capacity to top management. There was sometimes a remarkable freedom to express opinions and to participate both in discussions which preceded executive decisions and in the implementation of policy that followed, but it was taken for granted that the final authority and responsibility for policy was to be exercised by those in legitimate positions of authority.

A factor which seemed to worry some people was the fierce loyalty which some employees showed to their particular department. The suspicion arose that their departmental *esprit de corps* prevented their integration with the rest of the hospital. Our observations led us to doubt this. We found that it was true that the strongest loyalty and feeling of identification came within the smaller units, but just as people from well-knit homes can make the best citizens, so people from well-knit departments can be turned into the most loyal organization supporters. It is up to the administrator and the department heads to bring about constructive relationships.

We participated in two experiments whose purpose was to achieve just such a unity of feeling among departments. These were organized

under the direction of university extension teachers. In these meetings the heads of various departments took turns describing the work of their staffs, the changes they were facing and the kinds of problems they encountered in trying to schedule the work and to maintain a high level of performance. This exchange of knowledge appeared to bring about sympathetic insight and a desire to work together on common problems.

One example of the results of such a session was this. The operating room supervisor had the floor and she described the procedures and organization they were using. After her talk a receptionist asked her what the reason was for delaying information on the outcome of operations. She said that it was very embarrassing for her staff to have members of the patient's family sitting around the lobby waiting for news. They would ask for information, the clerk would phone surgery and be told that the operation was still going on. Then, before she could hang up the receiver she would see the surgeon strolling by pulling on his street gloves as he moved toward the door. The operating room supervisor replied that this was reasonable because the surgeon very seldom finished the job of operating. He would do the surgery and then leave the closing of the incision to his assistants. Many operations would continue for a half-hour after the chief surgeon had left the room. The admissions clerk heard this with amazement. It had never occurred to her before. She remarked with obvious relief that at last she knew what to tell the distressed family. The public relations factor here is obvious. In addition, when the operating room supervisor said that the ringing of the telephone was a distinct annoyance and a delay to their work, the receptionist promptly agreed not to call any more upon the promise that the nurses would call her at once when the patient was wheeled out of surgery. Thus this problem was handled with great satisfaction to both sides.

One aspect of the communication problem lies here: How far down the line should one carry this exchange of ideas? This appeared to be still undecided in most hospitals. The typical pattern of development was that as the hospital grew larger and busier, some increase in consultation down the line occurred. Usually this first involved top-ranking persons in top-ranking groups. For example, the doctors who became the heads of particular staffs were given more voice in policy matters. Then perhaps a few of the most trusted nurse supervisors were allowed to sit in on policy decisions, and so on. In the course of time as hospital-wide problems were experienced, more and more

participation was given until a majority of the supervisory staff was involved in committee work of some sort.

At the time of our study, this trend had gotten to just about this level. In one instance an effort was made to increase the feeling of belonging among rank-and-file employees by putting out a monthly newsheet containing information of institution-wide interest. In a few places meetings were being held for rank-and-file employees within certain departments. We didn't observe any interdepartmental meetings for people at this level. Whether this trend to encourage the participation of employees down the line would continue or not and whether if it did, it should be considered "progress" is beyond our knowledge. Certainly at the department head level it is important for the individual to be able to relate his staff effectively to the work of other portions of the organization and the ability to do so rests not only in having adequate knowledge but also in being motivated to do a good job in this respect. The motivation seems to be strengthened as identification with the whole institution increases.

Education and Unity

The multitude of technological and organizational changes which have been occurring in hospitals seemed to arouse a widespread fear of inadequacy among employees, together with a strong desire to learn. Educational devices were, like meetings, springing up everywhere. Much of the effort to learn was individual, but in addition a good bit was being done on an institutional level as well. The individual who went out alone to study sometimes experienced frustration when he returned, full of new ideas and with limited opportunity to express them. When the group studied together, the total effect was much greater, for each individual helped to bolster the morale of the next, new ideas were put into action, and cohesiveness within the institution appeared to grow as mutual understanding and interest increased.

In the religious hospital we studied, the administrator felt it desirable to bring formal university courses right into the hospital:

Some of our Sisters had been supervisors for twenty-five years but still they felt it was worth their while to get this additional training. This inspired the other nurses. They felt that if the supervisor on their floor thought it was valuable for her after all those years, maybe they weren't too old to get educated either, so they began taking the courses too. Now there are several of them going to the University each summer.

These classes provided college credits toward the B.S. degree. Moreover, they provided ample time for discussion within the group and since they were attended by both practicing supervisors and potential ones, the indoctrination of the younger members of the group in organizational thinking cannot be underestimated. From the administrator's point of view, one of the chief merits was the spirit of unity which grew from working and studying together.

There are too many types of experimental programs going on today to even attempt to list them. Institutes are being held for doctors in some places, for nurses in others, and for both groups together in still other situations. "Ward classes" or case-centered discussions in which doctors, nurses, and a wide variety of student nurses, doctors, and technicians are included, are extremely popular. There are educational workshops and institutes being given by the various hospital associations, not only for administrators but for directors of nurses and supervisory staffs.

In our experience, a feeling of pride is common among employees who are entrusted with the privilege of attending a distant conference and reporting back on what they learn. The reports aren't uniformly helpful, of course, but there is a pretty consistent enthusiasm and the experience is generally seen as a recognition of conscientious service. In itself, this provides an incentive to others. It is usual to find that employees who attend meetings of their own professional group, whether nurses, technicians, medical record clerks, or housekeepers, tend to return to their own organization with heightened morale. Apparently one wants to be proud of one's own institution and any comparison with other organizations causes a person to defend his own and to concentrate attention on its better points. In addition, the sharing of ideas and insights about a work situation helps to bring about a fresh perspective on it.

Conclusion

All of the hospitals we studied faced similar problems, although in differing measure. Old patterns of relationship were being outdated as hospitals grew in size and complexity and new patterns were still in process of coming into being. The growth of impersonality which resulted was bewailed by many persons. The tediousness of "bureaucratic interference" was bemoaned by those who resented the lengthening of the line of command. There was ample evidence to support such claims of malfunction. There was also evidence that many complaints

grew from a transitional stage of organizational development. To put it another way, it was not the biggest hospital studied which had the most problems. It was rather those hospitals which were still in the early throes of adjustment. Once established, it appeared that a large institution could function satisfactorily from most points of view, although its basis of unity must necessarily be more formal than that of a smaller one.

It was clear that the tempo of change was very much influenced by the example and attitude of those highest in the organization. The first part of this book dealt with relationships among trustees, administrators, and medical staffs. Evidently harmony is necessary at this level if it is to be won further down the line.

In some places, new ideas in communication and participation were experimented with gingerly and such experiments were occasionally ended by hasty retreats back to older, more familiar ways. In other cases new ideas were being greeted with enthusiasm and imperfect adaptations were followed by better ones as people gained skill and confidence. It was clear, however, that adjusting to change did not come easily anywhere but required work on the part of those responsible for organizational effectiveness.

We have discussed some of the many kinds of experiments in organization which were going on. One was the creation of new departments whose primary function was to centralize business controls. Such departments frequently encountered resistance on the part of line officers, but nowhere did we see them abandoned. Another series of changes affected the disposition of authority and responsibility. In all cases where we saw a change it was in the direction of a wider distribution rather than a narrower one. It included in some instances the appointment of administrative assistants. Elsewhere we saw executive supervisors put in control of large segments of the institution. In still other instances all department heads were being given a larger share of managerial functions and were becoming an integral part of the administrative team. In all of these instances there was typically a period of confusion until a common understanding came to be shared concerning the way the new system geared into more familiar aspects of the organization.

All of the hospitals were experimenting to greater or less degree with communication devices such as meetings. These were of various types and degrees of success, but all of them seemed to stem from a common philosophy. It was believed that the very act of drawing people

together and granting them the right of discussion would in itself exert a therapeutic influence on organizational harmony. It didn't always work out that way, but successes were sufficient to encourage further experimentation. We observed progress being made and saw that for the most part this was on a trial and error basis, each hospital learning from its own mistakes much more than from the example of others. This may not be the cheapest way to learn, but it appears to be an effective way.

Like meetings, educational devices were growing in frequency. In another chapter it was noted that the multiplication of pressures from outside agencies was often greeted with a sigh on the part of hospital administrators. In this instance, the administrator typically was grateful for the help offered him in getting and keeping his employees up to date. National hospital associations, public health agencies, and universities, as well as the many professional and occupational societies to which hospital employees belong, worked together to meet the challenge of the immense advances being won in the fields of medicine and medical technology.

Whether the strain on hospital organizations will ease with further passing of time remains to be seen. There may be a plateau ahead when administrators will have a chance to draw a deep breath and consolidate hard-won gains. In any event, it is safe to say that quite a while will pass before smugness and complacency will be widespread enough to be dangerous in the now exciting field of hospital administration.

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